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ABSTRACT

This document provides witnesses' testimonies and prepared statements from the Congressional hearing held in Los Angeles, California to examine the problems of the homeless and to suggest ways to alleviate some of the problems of the homeless. Opening statements are included by Representatives Augustus Hawkins, Edward Roybal, and Matthew Martinez. Witnesses providing testimony include: (1) Ernani Bernardi and Richard Alatorre, Los Angeles City Councilmen; (2) Gabriel Cortina, assistant superintendent for adult and occupational education, Los Angeles Unified School District; (3) Edward Eisenstadt, director, alcohol and residential services, Volunteers of America; (4) Rodger Farr, Los Angeles County Department of Mental Health; (5) John Haley, director, Mary Lind Foundation; (5) Martha Brown Hicks, president, Skid Row Development Corp.; (6) Maxene Johnston and Janet Larkly, Weingart Center Association; (8) Nancy Mintie, Inner City Law Center; (8) Bruce Monroe, Crime Prevention through Substance Abuse Treatment; (9) Buddy Nadler, Economic Development Committee; (10) Robert Nelson, Los Angeles Business Labor Council; (11) Steven Porter, Los Angeles City Community Development Department; (12) Bette Ripp, People in Progress, Inc.; (14) Thomas Settle, Wings Over Jordan, Inc. and Caring Hands Programs; (15) David Silva, Secretary Treasurer of Los Angeles Union of the Homeless; and (16) three homeless persons, Nick Brkich, George Mount, and David Quail. Prepared statements, letters, and supplemental materials are included. (NB)

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OVERSIGHT HEARING ON JOBS AND EDUCATION FOR THE HOMELESS

ED291035

JOINT HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND LABOR

AND THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

HEARING HELD IN LOS ANGELES, CA
MARCH 20, 1987

Serial No. 100-15

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and the Select Committee on Aging

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CONTENTS

	Page
Hearing held in Los Angeles, CA, on March 20, 1987	1
Statement of:	
Alatorre, Richard, Councilman, City of Los Angeles, 14th district	15
Bernardi, Ernani, Councilman, City of Los Angeles, 7th district	4
Brkich, Nick	208
Cortina, Gabriel, Assistant Superintendent for Adult and Occupational Education, L.A. Unified School District	118
Eisenstadt, Edward, Director, Alcoholism and Residential Services, Volunteers of America, Los Angeles	181
Farr, Dr. Rodger, Chief of Medical and Psychiatric Consultation Services Division, Los Angeles County Department of Mental Health	20
Haley, John, Director, Mary Lind Foundation	176
Hicks, Martha Brown, President of Skid Row Development Corp	136
Johnston, Maxene, President, Weingart Center Association	106
Larkly, Janet, Program Manager for Screening and Referral Services, Weingart Center Association	106
Mintie, Nancy, Inner City Law Center	141
Monroe, Bruce, President of Crime Prevention Through Substance Abuse Treatment	150
Mount, George	204
Nadler, Buddy, Chairman, Economic Development Committee	175
Nelson, Robert, Deputy Executive Director of Los Angeles Business Labor Council	132
Porter, Steven M., Assistant General Manager, Los Angeles City Community Development Department	129
Ripp, Bette, Director of Programs, People in Progress, Inc	186
Quail, David	206
Settle, Thomas A., Vice President, Wings Over Jordan, Inc., and Executive Director, Caring Hands Programs	196
Silva, David, National Coordinator of National Unit of Homeless, Secretary Treasurer of Los Angeles Union of the Homeless	202
Prepared statements, letters, supplemental materials, etc.:	
Bernardi, Ernani, Councilman, City of Los Angeles, prepared statement of	10
Cortina, Gabriel, Assistant Superintendent, Los Angeles Unified School District, prepared statement of	121
Eisenstadt, Edward, Director, Alcoholism and Residential Services, Volunteers of America, Los Angeles, prepared statement of	183
Farr, Dr. Rodger, Chief of Medical and Psychiatric Consultation Services Division, Los Angeles County Department of Mental Health:	
"A Programmatic View of the Homeless Mentally Ill in Los Angeles County," article from International Journal of Family Psychiatry, vol. 6, No. 2, 1985	85
"A Study of Homelessness and Mental Illness in the Skid Row Area of Los Angeles," executive summary	31
Statement of testimony of	25
"Treating the Homeless: Urban Psychiatry's Challenge," article entitled	58
"Group Awards $500,000 in Grants to Agencies Assisting Homeless," article from Los Angeles Times, February 20, 1987	212
Haley, John, Director, Mary Lind Foundation, prepared statement of	179
Hicks, Martha Brown, President, Skid Row Development Corp., prepared statement of	138

Page

Prepared statements, letters, supplemental materials, etc.—Continued
"Hope For The Homeless," article from Los Angeles Times, January 22, 1987 210
Larkly, Janet, Program Manager, Screening and Referral Services, Weingart Center Association, prepared statement of 113
Mintie, Nancy, Inner City Law Center, Los Angeles, CA, prepared statement of 145
Monroe, Bruce, President of Crime Prevention Through Substance Abuse Treatment:
Letter to Chairman Hawkins, dated March 31, 1987, with enclosure 171
Prepared statement with several attachments 151
Nelson, Robert, Deputy Executive Director of the Los Angeles Business Labor Council, testimony of 133
"One approach to the homeless . . . and one that works," article from the Los Angeles Business Journal, February 23, 1987 211
Porter, Steven M., Assistant General Manager, Los Angeles City Community Development Department, prepared statement of 130
Ripp, Bette, Program Director, People in Progress, Inc., prepared statement of 188
Schmidt, Jim, Executive Director, Fountain House, prepared statement of 215
Settle, Thomas A., Vice President, Wings Over Jordan, Inc., and Executive Director, Caring Hands Programs, prepared statement of 199
The Greater Los Angeles Partnership For The Homeless, statement of 213

JOINT OVERSIGHT HEARING ON JOBS AND EDUCATION FOR THE HOMELESS

FRIDAY, MARCH 20, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND LABOR,
WITH
SELECT COMMITTEE ON AGING,
Los Angeles, CA.

The committee and subcommittee met, pursuant to notice, at 2:35 p.m., in room 350, Public Works Building, City Hall, Los Angeles, California, Hon. Augustus F. Hawkins (Chairman of the Committee on Education and Labor) and Hon. Edward R. Roybal (Chairman of the Select Committee on Aging) presiding.

Members present: Representatives Hawkins and Martinez.

Select Committee on Aging member present: Representative Roybal.

Staff present: Ricardo Martinez, Pat Benson, Jeff Fox, Tod Bullen and Henry Lozano.

Chairman HAWKINS. The hearing is called to order. The hearing this afternoon on the subject of homeless is a joint hearing between the Education and Labor Committee and the Joint Hearing with the Select Committee on Aging.

I am Congressman Hawkins, Chairman of the Education and Labor Committee. To my left is a member of the Education and Labor Committee, and Chairman of the Select Committee on Employment Opportunities, Mr. Martinez. And to my right is Mr. Roybal, who is chair of the Select Committee on Aging.

We are very pleased to be here at the request of Mr. Roybal and Councilman Bernardi, and we express our appreciation to the city for the facilities in which we are here, and are conducting the hearing, and we look forward to the testimony of the witnesses.

The subject matter is obviously one of a number of issues before the Congress that includes education and immigration, tax reform, trade, and a host of other issues, but none is any more significant to us and certainly none is more significant to the nation that prides itself on its prosperity, its development, and on its compassion than how it treats its fellow citizens within its borders.

We have taken one feeble step in passing an emergency bill that provides somewhere in the neighborhood of $500 million. That is only a band aid, and only a temporary adjustment to a very difficult subject. We are here in Los Angeles which has a substantial homeless population to learn. And we believe that we are here not merely to have people theorize or to tell us how bad the problem is,

but we hope that out of the hearing we will obtain some concrete suggestions, recommendations, and that we will learn what some of the solutions may be as we will try to wrestle with this problem in Los Angeles.

We will obviously ask the witnesses to the extent that they possibly can to give us the highlights of their testimony, to not give us every word on every page of their documents. Sometimes those documents can be quite lengthy.

We would rather have an opportunity for questions and some clarification perhaps of some of the statements that are made, so we hope the witnesses will accommodate the time that we have allocated to the hearing this afternoon.

Be as brief as is practicable, but at the same time be as thorough as you possibly can. The Chair would like to yield at this time to our very distinguished—Yes.

Mr. SILVA. Congressman Hawkins. We only got word yesterday of this hearing, and we would like very much if we could, I submitted to Congressman Martinez a proposal that was sent to most members of the Congress and the Senate, a proposal that was not submitted to this body, that if we can have five minutes to talk towards that proposal.

Chairman HAWKINS. Are you scheduled as a witness this afternoon?

Mr. SILVA. No. We are not part of the panel because we did not know about this hearing. We are asking if we can speak as a witness today.

Chairman HAWKINS. Well, it is usual for us to follow the agenda that has been given to us. We however invariably try to locate some time so that others who may not be included will have an opportunity to express themselves. We anticipate that will be possible.

I can only promise you that if that works out that way, I have no way sometimes of controlling the witnesses. Some time some of our witnesses can consume a lot of time. I can try to be as generous as I can, but at the same time, try to—and I have already suggested that brevity sometimes is more effective than long-winded statements.

Mr. SILVA. Yes, we need only a few minutes.

Chairman HAWKINS. Well, we will try to allocate time, and I have no problem. And I am sure my colleagues have no problem with hearing from others who may not be on that list, and I am sure we will accommodate you.

Mr. MARTINEZ. Mr. Chairman, the letter he referred to that he handed to me is in front of Congressman Roybal. He gave us some additional copies there that we could make available.

Chairman HAWKINS. Well, in any event, your letter is going to be in the record as you have submitted that. It will be an official part of the record, and we will try to allocate some time near the end of the program this afternoon for you to verbally present it.

The Chair would like to yield to our distinguished colleague who is actually the inspiration for this hearing, Mr. Edward Roybal.

Mr. ROYBAL. Thank you, Mr. Chairman.

First of all, Mr. Chairman, I would like to express my personal appreciation to you and to Congressman Martinez for agreeing to

be present this afternoon to examine the growing and tragic problems of the homeless.

It is my hope that the expert testimony we will hear today will lead to a better coordination of resources and efforts on the federal level, as well as with state and local authorities. One of the keys to this endeavor must be to provide greater and more suitable education and employment opportunities for all of our citizens.

How we assist the chronically homeless will perhaps be one of the greatest challenges that we face throughout the 1980s. And I believe that that will be the challenge we will have to face in the decades to come.

Hearings before my Committee on Aging have revealed that many of our poorest elderly Americans do not receive housing assistance, do not receive any educational assistance, and are not even offered jobs particularly if they happen to be over the age of 50.

I remember a time when if you reached 40 you could not get a job. Well, for some reason or another those between 40 and 50 are doing better in this last decade than they did in the decade before. But once you reach 50, it seems it is almost impossible for people to get jobs.

And that is one of the things that the Committee on Aging is fighting against and something that we will have to be dealing with now and in the future. I would also like to extend my personal appreciation to Councilman Bernardi and to all those on his staff who worked behind the scenes to help with the arrangements for this joint hearing.

I greatly look forward to today's experts testimony, and to taking the recommendations back to Washington for the Congress' serious consideration. Whatever testimony we get today will of course become part of the record, and we will do everything possibe to implement, and pass the legislation that is necessary to meet your recommendations.

I yield back, Mr. Chairman, the balance of my time.

Chairman. HAWKINS. Thank you, Mr. Roybal. Mr. Martinez, would you like to make a statement?

Mr. MARTINEZ. Thank you, Mr. Chairman. Mr. Chairman, you are to be commended for convening this meeting, and Mr. Roybal is to be commended for calling upon you to convene this hearing.

I am pleased to be here with both of you today to examine the plight of the homeless. As a U.S. Conference of Mayors survey recently reported the demand for emergency housing has jumped by 50 percent last year in Los Angeles alone. This increase very probably indicates that Los Angeles has the largest number of homeless in the country, and this number has been estimated to be as high as 34,000 to 50,000.

This ever growing population deserves the immediate attention of this city, this county, this state, and the federal government. No longer can millions of dollars be spent to just temporarily assist the homeless. Although money is essential, it is only a temporary and wasted solution unless it is incorporated into long-term plans.

These long-term plans must include as Mr. Roybal has stated, job training, job referral, and education to give this city and this nation's homeless an opportunity to provide for themselves. Emergen-

cy shelters and free meals are just the first step in assisting the less fortunate. But it is only a first step.

The tragedy of the homeless continues to worsen as more and more people take to the streets. I believe that we will see a continuing increase of this problem unless the federal, state and local governments take immediate steps to develop effective, durable and workable policies. The U.S. House of Representatives has already taken a step in the right direction by passing homeless legislation several weeks ago, H.R. 558, that the Chairman referred to.

I believe that the government has a moral obligation to help these people, and because the Constitution says so. The Preamble to the Constitution which promulgated the law of the land called for that new government to promote the general welfare, to insure domestic tranquility, and to secure the blessings of liberty to ourselves and our posterity.

To that end, we need to stop blaming the victims homelessness for their helplessness as well as seeking out who is responsible for the plight of the homeless. As American citizens we are all responsible. We all share in the blame. And we must all accept the responsibility for correcting the current crisis of the homeless.

As a nation we need to start working together to establish some long-term policies to assist the homeless rather than wasting time idly watching their plight while pointing fingers at each other. I hope that this hearing will help us establish some plans to achieve long-term goals to assist the homeless, and I look forward to the testimony of our witnesses because I believe they have the expertise to lead us in the right direction.

Thank you, Mr. Chairman.

Chairman. HAWKINS. Well, thank you.

According to the agenda, we will hear first from members of the City Council. And it is a pleasure for the chair first to call on Ernie Bernardi, Councilman for the 7th District for his statement.

Councilman Bernardi, may I also indicate that after you have testified as a witness, the members will be pleased and honored if you would care to join us to so do so. I know you are interested in this subject, if you would like to sit in as a representative of the City of Los Angeles, we would be pleased for you to join the members of the team up here as it were.

Mr. BERNARDI. Thank you, Mr. Chairman. I would be honored to join with you.

STATEMENT OF ERNANI BERNARDI, COUNCILMAN, CITY OF LOS ANGELES, 7TH DISTRICT

Mr. BERNARDI. Chairman Hawkins, Chairman Roybal, Representative Martinez, first let me thank you for convening this meeting on this very important and very critical subject, the homeless and the job situation that we are confronted with with respect to creating some of the homeless problems that we are now faced with.

I think it is a wonderful day for the City of Los Angeles that you are here and deeply involved in this important subject. I share with you a deep interest in the problem of homelessness. And to that end, my committee has held several hearings on this issue over the past years.

It has been said that a society is judged by how it treats its least fortunate members. In a 1984 report, the Department of Housing and Urban Development labeled Los Angeles "the homeless capital of the nation." The situation is even worse today. We are certainly not proud of this label, and we want to work jointly with the federal, state and county governments to remove it.

Intergovernmental relations in the past have too often been marked by a lack of cooperation particularly regarding the problem of homelessness. Various estimates have been made of our homeless population and you heard some mention by Congressman Martinez, and they range from 500—this is a survey that the Los Angeles Police Department made one mid-winter night on the streets about two years ago to 50,000 countywide.

My own feeling is that no one really knows exactly how many homeless people there are in Los Angeles because they are difficult to locate and count and are constantly on the move. The homeless include people of all ages and racial and ethnic groups.

Single men, women and children as well as families. The able-bodied and able-minded as well as those physically impaired, mentally ill or addicted to substances, those recently unemployed, as well as those who have never been employed or are incapable of ever being employed, and veterans of course of military service.

I share Congressman Roybal's concern that many of our poorest, older Americans are falling through the cracks of housing and community service assistance programs, and I find it most disturbing that women and families are perhaps the fastest growing group of the homeless.

The problem is city-wide in Los Angeles, not just in the downtown skid row area, although it is most highly concentrated there. It has gotten to be too common a sight. Almost everywhere on the streets of Los Angeles helpless, seemingly hopeless, unkempt individuals wandering aimlessly, talking to themselves or pushing shopping carts. That in essence is their home. The urgent relief for the homeless act, Resolution 558, and the other homeless aid bills pending in Congress will go a long way towards providing for the basic needs, shelter, food and health care of the homeless.

You and your colleagues in the House deserve to be commended for passing the bill. You have taken the lead on this critical problem at a time when other levels of government are rightfully being accused of indifference and buckpassing.

The Act will assist us to more fully utilize any unused, abandoned government buildings and structures as emergency shelters. We recently started such a program with Los Angeles city owned buildings, but it should also be done with surplus federal, state and county buildings.

I understand that there are federally owned, under-utilized structures in the Los Angeles area that could be converted into use as emergency shelters. In other cities, this has been done successfully with Defense Department buildings.

One of the basic guarantees of our democracy contained in the Declaration of Independence is life, liberty and the pursuit of happiness. It is difficult for me to imagine how people can live, be free, and be happy without eating regularly, and having a roof over their heads at night. But we must do more than merely provide

three hots in a cot if we are to break the downward spiral that homeless people quickly fall into once they are on the streets.

We must also treat and attempt to rehabilitate those with physical or mental problems, cure them of their addictions or psychosis. It is clear to me that our laws and policies in California first of all must be changed to permit chronic alcoholics and the mentally ill to be removed from the streets and given the treatment that they so critically require.

Otherwise their lives would be deadended, and we will be feeding and warehousing the same people constantly. Although New York City removes homeless people from the streets during freezing weather whether or not they want to go, such mandatory actions involve serious constitutional problems.

In California, our hands are virtually tied by statutory law which makes public drunkenness a crime, yet a court decision, the Sundance decision, requires public inebriates to be treated as sick people and released from custody only hours after being picked up, no matter what their condition.

Prior to the Sundance decision in 1978, the police department made as many as 60,000 arrests a year for public drunkenness, most of these arrests were actually for their own protection. In the years following that decision, annual arrests dropped to as few as 6,000, while those not arrested are left to wander the streets unprotected.

Due to limited treatment facilities and jails, police have virtually given up trying to take them into custody, and as I have indicated, that custody was generally for their protection. Our streets have also become outdoor asylums for the mentally ill as a result of a policy that is a long word "deinstitutionalization" begun in the 1960s in California.

Under this policy, mental patients were to be released early from hospitals to community treatment centers. Unfortunately, these centers were never built, and people were still released. The longest that mentally ill people can now be held without a hearing is 72 hours.

The next vital step after rehabilitation and after classification should be to provide the skills and training that will help people get jobs and lead productive lives. A key part of the process of assisting the homeless must be to make them aware of the benefit programs that are available for which they are eligible.

For example, only a fraction of the mentally ill homeless are currently receiving SSI benefits. Efforts must be made to locate these people and help those who are eligible for such benefits to apply. Further, those who come off the streets into shelters or drop in centers, should be carefully evaluated to determine their needs and which programs would benefit them.

A referral should then be made to the appropriate agency or service provider. One of our goals should be to establish at least one main facility in Los Angeles that would serve as a referral and service center for the homeless. Its doors would be wide open to all homeless people who would be evaluated upon entrance to determine their needs.

All services such as shelter, food, sanitation, counseling, medical and job training would be available at the site or provided offsite by referral.

To conclude, our long-term goal should be to return people to productive lives rather than merely warehouse them. This goal is one that we are obliged to strive for in a free, humane and affluent society like ours. We must not shrink from it.

Chairman HAWKINS. Thank you, Councilman Bernardi. The Chair will entertain any questions that either of my colleagues would like to propound. Mr. Roybal.

Mr. ROYBAL. Mr. Chairman, I have one question. First of all, Councilman Bernardi, I would like to compliment you on an excellent statement. It covered the problem in a very excellent manner.

But there is one question I want to ask, and that is on your first page, you said the following: "Intergovernmental relations in the past have too often been marked by a lack of cooperation, particularly regarding the problems of the homeless."

You put that in the past tense. Has it improved any in the last six to eight months?

Mr. BERNARDI. Well, there has not been any improvement in the last six or eight months, and unfortunately, the city has threatened a lawsuit against the county to get the county to share its real responsibility, the one designated by the state to really assume a substantial share of the responsibility.

Fortunately, as a result of that, and we are looking forward with crossed fingers, the mayor and Mr. Antonowich of the board of supervisors had held a meeting and decided to establish a task force. Now, task forces have been established before, but we hope maybe with the climate changing, with the attitude of the council and the mayor, maybe now the board of supervisors, hopefully the climate will change and we can make some progress.

Mr. ROYBAL. Without the task force and, none of that fancy manuevering, what kind of cooperation are you getting from the federal government?

Mr. BERNARDI. Well, there have been many programs that you have instituted on the federal level, but with respect to the problem of being able to use some of the funds to maybe rehabilitate or to update some of our empty city buildings, we really have not had much assistance from anyone.

I understand that some of the new federal legislation addresses itself to that question, and we are very encouraged and I hope that we will aggressively pursue our—pursue whatever effort it needs or use whatever effort it needs to get our share of the funds so we can do something about it.

Mr. ROYBAL. I think that that endeavor is in place and that something will develop. I am making reference particularly to the use of federal buildings to house the homeless.

Has any direct effort been made to include federal buildings in this program?

Mr. BERNARDI. Congressman Roybal, Congressman Hawkins, Congressman Martinez, it has taken two or three years to get the city council to open up one of its many facilities that it has, and of course, as you are aware and you and I served together here in the

city council, and it was such a pleasure at the time, there is strong resistance in the community for providing some of these shelters.

But I think most of the resistance can be at least minimized if we assure people like in the skid row area and the business people are rightfully concerned, if we can assure them that this is a city-wide problem, and that every area of the city is going to have to assume its share of the responsibility doing something about this unfortunate situation.

Mr. ROYBAL. Well, one last thing, and that is that I welcome the opportunity of working with you and trying to develop a procedure whereby federal buildings can also be used for that purpose.

Mr. BERNARDI. I want to commend the judge, one of your judges here, Judge Harry Fragerson, who is deeply interested in that and wants to participate also fully in making federal buildings available including his court.

Mr. ROYBAL. Thank you.

Chairman HAWKINS. Just a minute, please. I yield to you.

Mr. MARTINEZ. All right. Thank you, Mr. Chairman.

Yes, Mr. Bernardi. You were talking about the model program that you founded which provided assistance to mentally ill people that are a part of the homeless. In the proposal that is before the Senate now, which the chairman referred to earlier in his opening statement, there is $50 million designated for block grants to communities to provide services for these people. In that also there is $75 million for shelter grant programs for under-utilized facilities to provide a program for the homeless.

There is in Saugus out here an old sheriff's facility that has about 600 acres and some dilapidated buildings and I am wondering if that would not be a good place to place a facility.

You mention the legal obstacles you have to overcome because you only hold these people for a certain amount of time when you pick them up. But I was thinking that you could provide this place for them, and have the health department provide all of the services, and run the facility using some of money from the federal government.

Would that be any kind of a solution for you?

Mr. BERNARDI. Yes, it would be a solution. It has been suggested for many years, and it has been on that wheel. It just keeps turning around and around because originally when that facility was purchased, and I believe Mr. Roybal was probably in the council at the time, the people in the City of Los Angeles voted a bond issue to buy that place as a rehabilitation center for the alcoholics, for the people that had a problem with liquor.

State law was changed and placed a responsibility on the county, and as a result the city then backed away from using that facility. It is a beautiful spot, and the facility that was built there was very attractive, very functional and unfortunately, it has been deteriorating, and we have been going around and around. It has been kind of one of those deals between the city and the county of trying to make some money off the deal.

And I felt frankly that we ought to lease it to the county for one year if they will willingly take over the operation of the facility. But now again, we have some serious political problems because

there have been a lot of homes built around it, and again we have this other situation that we have to confront with.

But it would be an ideal spot.

Mr. MARTINEZ. I guess the bottomline is, that if these monies be come available from the federal government in the matching grant form and section 8 certificates could provide some monies for providing federal assistance, I would think that with all that available, we might be able to talk the necessary people in the necessary positions into doing something with the family now.

Mr. BERNARDI. Well, I am encouraged by your meeting here, and by the legislation you have passed, and I hope that this will now trigger more activity on the part of the city and the county and give this very serious problem the higher priority than it has had in the past several years because it is a mounting problem.

It is not going to go away, unless we take some aggressive action, at least to get the people who are in this situation, get them under some other training program, your job training program. Because there are at least a third of those who can be rehabilitated and can be converted to a very productive life.

Mr. MARTINEZ. Thank you, Mr. Bernardi. I yield back.

Chairman HAWKINS. Thank you, feel free to join us, councilman.

Is Councilman Alatorre in the audience. Councilman Richard Alatorre, 14th District. Councilman, we are very pleased and honored to have you as a our next witness this afternoon.

[Prepared statement of Ernani Bernardi follows:]

PREPARED STATEMENT OF ERNANI BERNARDI, COUNCILMAN, CITY OF LOS ANGELES

Chairman Hawkins, Chairman Roybal, Representative Martinez, (and Honorable Committee Members):

My name is Ernani Bernardi. I am a member of the Los Angeles City Council and Chairman of the Council's Public Health, Human Resources and Senior Citizens Committee.

I would like to thank Congressman Roybal, my former colleague on the City Council, for accepting my invitation to hold this hearing today in Los Angeles, and Congressmen Hawkins and Martinez for their participation. I also appreciate the opportunity to appear before you.

I am deeply interested in the problem of homelessness and my Committee has held hearings on this issue over the past two years.

It's been said that a society is judged by how it treats its least fortunate members.

In a 1984 report, the Department of Housing and Urban Development labeled Los Angeles "the Homeless Capital of the Nation." The situation is even worse today. We're certainly not proud of this label and we want to work jointly with the Federal, State and County governments to remove it.

Intergovernmental relations in the past have too often been marked by a lack of cooperation, particularly regarding the problem of homelessness.

Various estimates have been made of our homeless population. They range from 500, by the Los Angeles Police Department one winter night two years ago, to 50,000 Countywide. My own feeling is that no one really knows exactly how many homeless people there are in Los Angeles because they are difficult to locate and count and are constantly on the move.

The homeless include people of all ages and racial and ethnic groups; single men, women, and children, as well as families; the able-bodied and able-minded, as well as those physically impaired, mentally ill, or addicted to substances; those recently unemployed, as well as those who have never been employed or are incapable of ever being employed; and veterans of military service.

I share Congressman Roybal's concern that many of our poorest, older Americans are falling through the cracks of housing and community service assistance programs and I find it most disturbing that women and families are perhaps the fastest growing groups of the homeless.

The problem is City-wide in Los Angeles -- not just in the downtown Skid Row area, although it is most highly concentrated there.

It's gotten to be too common a sight almost everywhere on the streets of Los Angeles: helpless, seemingly hopeless, unkempt individuals, wandering aimlessly, talking to themselves or pushing shopping carts.

The Urgent Relief for the Homeless Act (HR 558) and the other homeless aid bills pending in Congress will go a long way toward providing for the basic needs (shelter, food, and health care) of the homeless.

You and your colleagues in the House deserve to be commended for passing this bill. You have taken the lead on this critical problem, at a time when other levels of government are rightfully being accused of indifference and "buck passing."

The Act will assist us to fully utilize any unused, abandoned government buildings and structures as emergency shelters.

We recently started such a program with Los Angeles City-owned buildings, but it should also be done with surplus Federal, State, and County properties.

I understand that there are Federally-owned, underutilized structures in the Los Angeles area that could be converted into use as emergency shelters. In other cities, this has been done successfully with Defense Department buildings.

One of the basic guarantees of our democracy, contained in the Declaration of Independence, is "life, liberty, and the pursuit of happiness." It's difficult for me to imagine how people can live, be free, and be happy without eating regularly and having a roof over their heads at night.

But we must do more than merely provide three "hots (meals) and a cot," if we are to break the downward spiral that homeless people quickly fall into, once they are on the streets. We must also treat and attempt to rehabilitate those with physical or mental problems -- cure them of their addictions or psychoses.

It's clear to me that our laws and policies in California must be changed to permit chronic alcoholics and the mentally ill to be removed from the streets and given the treatment that they so critically require. Otherwise, their lives will be dead-ended and we will be feeding and warehousing the same people constantly.

Although New York City removes homeless people from the streets during freezing weather, whether or not they want to go, such mandatory actions involve serious Constitutional problems.

In California, our hands are virtually tied by statutory law which makes public drunkeness a crime, yet a court decision (Sundance) requires public inebriates to be treated as sick people and released from custody only hours after being picked up.

Prior to the Sundance decision in 1978, the Police made as many as 60,000 arrests a year for public drunkeness. Most of these arrests were for their own protection. In the years following that decision, annual arrests dropped to as few as 6,000, with those not arrested left to wander the streets unprotected. Due to limited treatment facilities in jails, police have virtually given up trying to take them into custody for their own protection.

Our streets have also become outdoor asylums for the mentally ill, as a result of a policy ("deinstitutionalization") begun in the 1960's in California. Under this policy, mental patients were to be released early from hospitals to "community treatment centers."

Unfortunately these centers were never built, and people were still released. The longest that mentally ill people can now be held without a hearing is 72 hours.

The next vital step after rehabilitation should be to provide the skills and training that will help people get jobs and lead productive lives.

A key part of the process of assisting the homeless must be to make them aware of the benefit programs that are available for which they are eligible.

For example, only a fraction of the mentally ill homeless are currently receiving SSI benefits. Efforts must be made to locate these people and help those who are eligible for such benefits to qualify.

Further, those who come off the streets into shelters or drop-in centers should be carefully evaluated to determine their needs and which programs would benefit them. A referral should then be made to the appropriate agency or service provider.

One of our goals should be to establish at least one main facility in Los Angeles that would serve as a referral and service center for the homeless.

Its doors would be wide open to all homeless people who would be evaluated upon entrance to determine their needs. All services, such as shelter, food, sanitation, counseling, medical and job training would be available at the site or provided off-site by referral.

To conclude, our long-term goal should be to return people to productive lives, rather than merely warehouse them.

This goal is one that we are obliged to strive for, in a free, humane, and affluent society like ours. We must not shrink from it.

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STATEMENT OF RICHARD ALATORRE, COUNCILMAN, CITY OF LOS ANGELES, 14TH DISTRICT

Mr. ALATORRE. Thank you very much, Congressman Hawkins. Congressman Roybal, Congressman Martinez. First of all, let me also extend the appreciation of the city for your foresight in conducting hearings here in Los Angeles to a problem obviously most of you know, and know it firsthand. And hopefully together we can come up with some ideas and concrete suggestions so that we begin to address it not on a piecemeal basis, but hopefully on a long-term basis.

What basically I have to say is not really new. I want to add my voice to those who say that we are not getting a handle on any aspect of homelessness, and what I think should be done to correct our approach.

This hearing seeks to address jobs in education for the homeless population, yet from all I can see, there is no framework to address those two aspects of homelessness. We have not even really addressed shelter yet or food or the basic health and sanitation problems.

All of those basic needs must be addressed so that the people are sufficiently rested, nourished and alert enough to listen, to learn and to acquire the skills as well as to seek employment, education or re-education and a new life. Those of us who have had some jurisdiction over the problem and those organizations who provide services are not listening or talking to each other.

We have all engaged in our own turf wars for resources that our groups have the solution. We are not coordinating our efforts or sharing our long-range goals or even short range objectives. Admittedly, this problem is not an easy one to talk about or to coordinate because it is so massive.

The lack of jobs results from vast changes in the economy including the many layoffs from factories and other industries and the changes in the kinds of skills that are necessary to obtain work.

The problem results from the callousness and the insensitivity of the present state and federal administrations in the wholesale dismantling of many social services, programs without providing any alternative ways for elderly, the marginally employed, and the poor people to survive.

The problem involves our shortsighted approach to land development in which quality, affordable housing is torn down and never replaced. So much for who and what is responsible. The problem is here and it is getting worse, and until we begin starting to work on a coordinated basis, the problem is going to continue to be unmanageable.

What we need at the local levels are a central coordinating body to identify the problems and resources for the local homeless population. We can then marshal the direct, the referral services to targeted groups and develop flexibility in responding to the changing homeless population.

Here in Los Angeles, more than one-third of the homeless population come from families. Five years ago the makeup of this population was different. These and other changes as well as other al-

ternatives that we seek out are part, not a full solution to the problem, but a piecemeal approach.

I authored a motion in the Los Angeles City Council to involve the United Way and all levels of government in developing a cohesive policy to evaluate and to deal with the homelessness. I think that this kind of planning is essential on a local, state and national basis.

The local and national policies must continue to shift from emergency shelter buildings and other bandaid approaches to a permanent long-range solution. As we develop our local planning and coordinating, we need the parnership of the federal government.

Right now funding policy is being made at the top levels without looking at what agencies must deliver at the local level. For example, right now the federal funds for job training only pay agencies whose trainees actually complete a program.

So in order for the agency to survive, it must restrict its application to those who have a high probability of success. In other words, those people who could survive without a program, there are no incentives, no incentives being given for agencies to spend the time in motivating those people who have given up or abandoned our particular system.

Those are the hardcore homeless, jobless people as well as the uneducated masses that we have in our society. Those are the hardcore opportunities to afford themselves, or that their lives have any difference or have any real meaning.

So really in closing, in order to deal with the problem effectively here at the local level. It really does not take one body to work by itself, but it takes a coordinated approach from all levels. I guess all of us are responsible in one way or another for the problem, and we all have to begin to work together to hopefully find the solution.

And not just a temporary solution because as I believe Mr. Bernardi said, this is not going to be a population that is going to change overnight. I think we have a homeless problem today as we had a homeless problem many, many years ago, but the problem has increased. The changing populations have dictated different approaches, and hopefully we can begin to coordinate better and to use the resources that we all have to ultimately find a plan that is going to work but not a plan that is going to respond, but a plan that will work in the long-term interests of all of the different levels of government and society and certainly can be of assistance here in the City of Los Angeles that is considered to be the homeless capital of the country.

For whatever reasons, people are here. They are here and we have to begin to address their particular problems and some of them are very unique to the homeless populations. The population that we once thought were the homeless of our country are no longer. They are families. They are young. They are old.

The one thing that they share in common is a hopelessness and a frustration that they have about the potential for government and the private sector in dealing with an extremely serious problem and with that I thank not only you Chairman Hawkins, but Congressman Roybal who has been a true advocate for the people that

are in great need along with you and along with Congressman Martinez.

To me it is a privilege to have an opportunity to testify before all three of you. With that I conclude.

Chairman HAWKINS. Thank you, Councilman. Any questions? Mr. Roybal.

Mr. ROYBAL. I have one, Mr. Chairman. I am interested in the central coordinating body in which you state that this body would plan and administer programs for the aging, or for the homeless.

Would this body be made up of public officials, or would it be a combination of public officials, bureaucrats or others. What would the makeup of this body be?

Mr. ALATORRE. Well, I think that we have to have individuals at top levels of responsibility whether they be elected representatives or whether they be representatives at the highest level of government in the respective agencies that are supposed to or not involving themselves in the problem.

Mr. ROYBAL. But it would be an official body, would it not?

Mr. ALATORRE. The body as I envision it here in Los Angeles would be a body of experts in bringing together the knowledge that people have in the private sector as well as in the public sector, whether they be public officials, and because of the time constraints of many public officials and the inability to be able to meet on a moment's notice, we need top level people, representatives of the federal government, representatives at the state level, and representatives of our own city agencies along with the experts in the area that are not affiliated with government.

Mr. ROYBAL. But the body would be formed by action of the city council and by official action also of the board of supervisors, is that correct?

Mr. ALATORRE. Oh, sure. I guess one of the problems is that——

Mr. ROYBAL. That is what I was going to get at, whether it was an official body.

Mr. ALATORRE. Oh, absolutely. It has got to be all levels. We have our turf problems, and I just look at it this way, this problem is so massive that anybody that we can involve in the solution of it I think is important.

But we have to have people at decisionmaking levels talking to one another. The federal government through officials whether they be elected or representatives of the federal government, but people that have an interest, that have an expertise, and have the will to put a body like that together irrespective of who is the chairperson of it, or who is not the chairperson of it.

But I think that what we passed at the city council level was the calling of a summit by officials at all levels of government as well as organizations that are out there working on a day to day basis with the homeless population so that we can begin to coordinate it.

Because usually we don't know what each other is doing about it. And I think together we can come up with a coordinated approach and provide the assistance that is necessary to individuals or organizations that are involved on a day to day basis with the homeless population.

Mr. ROYBAL. Thank you.

Mr. ALATORRE. Thank you very much.

Chairman HAWKINS. Any further questions? Mr. Martinez?

Mr. MARTINEZ. I have a clarification. What I envision that you are saying is a coordinating council made up of representatives from the different agencies that would be providing the services so that you have somebody from the health department who is going to provide those services. Somebody from HUD who is going to provide the section 8 housing.

Somebody from all of those agencies that are going to provide all of the necessary services so that they are coordinated and do the most good for the people they are trying to help.

Mr. ALATORRE. And come up with a hopefully a coordinated plan that all can have, that we can have a consensus with so that we can begin moving forward so that we are not just doing patchmeal and bandaid approaches. This is as I said in my testimony, this is not a problem that is going to disappear.

If anything, with the economic conditions in our society today and with the economic policies of the present administration it is probably going to just increase the numbers of people and the kind of person that once was able to take care of him or herself and their families might end up being part of the homeless population.

And we are seeing it today, and obviously, one of the very significant populations that we have that are part of the homeless are the mentally ill, the people that were thrown out of hospitals. The idea that the money was going to follow them in to the local communities, and somewhere along the way it did not follow them.

And we have people out there today that are in need of help.

Mr. MARTINEZ. One last question. You know, part of your speech theme was long range plans, long-term education and job training to provide some alternatives for these people that they do not have now.

I have to agree completely with you and commend you for that thought. A part of the Act before the Senate now, H.R. 558, deals with amending the Job Training Partnership Act. I see on the witness list we are going to have Gabe Cortina who is the principal at the skills center in East Los Angeles.

Mr. ALATORRE. I think he is like assistant superintendent that deals with all of the job training programs throughout the city of Los Angeles.

Mr. MARTINEZ. Yes, you are right. I know him from that previous description. And he will probably address this issue you raised the question rather, even though they may expand the job training program to the homeless, there is the question of the performance contract and the standard of the Act itself. Some of us have had problems with that because it gleans and takes those that have the greatest potential for receiving the training and being placed.

And that is the only way the person providing the services gets paid. I do not know for sure and maybe the chairman can clear this up, but I thought that these people would be provided services because to qualify as homeless means they would be evaluated under a different criteria, the 10% window, which allows them to service homeless.

Mr. ALATORRE. Well, right now today, we have just been going through months, actually 18 months of struggle with this particular problem of contracts, and what they should be based on.

We have to obviously follow the federal mandates which is job performance oriented, or Department of Labor. That is what they have set out, and we have just completed negotiations on that and hope that—there is obviously consensus by most of the people involved.

But, yes, I believe that the way it is set up discourages chance taking because of they are only going to be paid according to—they will be paid up front monies, but somewhere along the way they do not complete the training, they are not going to be reimbursed. And we are not talking about rich agencies.

Whether it would be a public agency like the school system. None of them are rich. Some are more capable of dealing with it than others, but it is not just the homeless population that we are talking about. We are talking about the hardcore unemployed that are not homeless, the troubled youth that have not been able to acclimate themselves very well to public institutions like the educational system.

There are bonus points for it, or money that is support for it that is out there as an incentive, but I just really wonder whether we are going to even meet not just the homeless population but whether we are even going to meet the hard to serve youth of our community and the hardcore unemployed with this system. I am willing to try anything.

And all my deliberations with the department has always been so that there is clarity. And you try and provide assistance and do not make it a detriment if there are agencies out there that are serving that segment of the population. The homeless population is not going to be easy to serve.

And I think all of us have to recognize that, but are we going to turn our backs to men and women, young and old from getting service or from those that want to avail themselves of training opportunities. See, shelter is just one aspect of the problem, and hopefully, there is a percentage that I know that will never get out of the system.

But then there is a significant percentage of those if given the opportunity will avail themselves of not only shelter but training opportunities, educational opportunities and hopefully we can move them out of the vicious cycle that they are in today.

Mr. MARTINEZ. I agree with you. Thank you, Mr. Chairman.

Mr. ALATORRE. Congressmen, thank you very much for the opportunity.

Chairman HAWKINS. The first panel which is now being called. As your names are called, would you kindly come to the witness stand.

Dr. Rodger Farr, Chief of Medical and Psychiatric Consultation Services Division, Los Angeles County Department of Mental Health.

Maxene Johnston, President, Weingart Center Association. Janet Larkly, Program Manager for Screening and Referral Services, Weingart Center Association. Would those persons be seated at the witness table.

The panel is scheduled 2:45 p.m. to 3:05, and we are much beyond that time already. That is roughly twenty minutes. If my

mathematics is correct, that gives each witness roughly five minutes to leave about five minutes for questioning.

We will try to stick to these schedules. I am not so sure we will, but anytime we don't stick to them, it is just going to deprive somebody else of an opportunity to present a view. So I suppose we got to start out with a little compassion at the very beginning.

With that as an introduction, which is not obviously designed to embarrass anyone, may I then call on you, Dr. Farr, to be the first witness.

STATEMENT OF DR. RODGER FARR, CHIEF OF MEDICAL AND PSYCHIATRIC CONSULTATION SERVICES DIVISION, LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

Dr. FARR. Thank you very much, and I appreciate the opportunity to testify today.

I just wanted to thank each of the Congressmen, Hawkins and Martinez and Roybal, for the opportunity that they have presented and the interests that they have, as well as Councilman Bernardi who was I feel championed the homeless causes here in the city council chambers.

In fact, in his earlier testimony he took about half of my material, so he decreased my need to talk quite so long. It was a very excellent presentation.

I would like to also point out in the testimony that I handed in. We did it very early this morning, so there are a number of errors, but I hope you get the gist of it. I have also included with it and handed in for the record four documents including our research project that we have just finished, the two year study on homelessness and mental illness in Los Angeles, and several articles which I recently did on dealing with problems and developing programs for the homeless mentally ill.

I have spent the majority of the last five or six years working with the problems of the homeless, mentally ill here in Los Angeles and assisting other cities and states in trying to understand and reach out to this troubled and helpless group of people. And I am certainly glad that Congress has now recognized the seriousness of the homeless problem that exists in the United States today and is attempting to do something about it.

I do not think, however, that we as a nation have come to full grips with the magnitude of the homeless problem or the seriousness which it foretells for us as a nation, and for us as a society.

It is my firm belief that homelessness in America is a problem of catastrophic proportion which is the result of some very serious problems that we have in the very fabric of our society.

As was mentioned earlier, Los Angeles has been dubbed the homeless capital of America, and we have 30,000 to 50,000 homeless here. While some of the homeless are certainly natives to our county and to the state, we find that many more are bussed in and now planed in and brought here, and we in many ways have become the repository of the homeless problems across the country.

The homeless comprise a very heterogeneous group of individuals with many multi-faceted problems, and I think their only common link is their homelessness. The economics of their impoverishment

is only an additional compounding problem or symptom of the underlying inability to function in our society today. I think this function in most cases is the result of some underlying root cause or problem such as chronic mental illness or some vocational or economic reason.

If these root problems are causes of homelessness are not understood and addressed, there may never be any permanent solution to the homelessness. In some cases, sheltering the homeless without simultaneous programs to resolve these root causes may only compound and reinforce their homelessness.

In the past several years I have observed what I feel to be the institutionalization of the homeless going on in many of our large cities around the United States. Some of the programs are addressing only the immediate needs of the homeless in terms of the sheltering and feeding them, but do not address the underlying root causes of homelessness and have tended to perpetuate that homelessness.

I fear we are on the threshold of creating a new homeless industry here in the United States. I am furnishing to the members as I said the research paper which goes into a lot of detail concerning some of the particular statistics that we found in terms of the degrees of mental illness, the types of mental illness, the social problems, the relationships with their families, the age groups, the demographics, the racial distributions and this type of thing which I think when you have time, you can review and will be very interesting to you.

I would just like to point out as a result of our study and some of the earlier studies I did, some of the root causes of the homelessness as I see it.

One is the severe and chronic mental illness which comprises anywhere from 30 to 50 percent of the chronically homeless population. Second is alcohol and drug abuse problems. In our recent study we found almost 40 percent of the homeless had a severe drug or alcohol problem.

The third is social, cultural and family related problems. It is interesting that we found that 60 percent of the homeless adults we interviewed had never been married. And of those that had been married, very few had any relationship at all with their families, any significant relationship.

I think that this causes considerable concern on my part that the altering social patterns of the last thirty years in the country have contributed to the breakdown in the family, both in terms of the close family ties as well as the commitment on the part of family members to care for and support family members who have chronic problems or are in need of help.

A fourth cause are what I call vocational obsolescence. I think the last thirty years we have seen major shifts in the occupational and vocational opportunities afforded the average citizen of the United States. We now find individuals who have marginal vocational skills who have found themselves permanently out of work through the advance technological society which we have now developed going into the 1980s.

The fifth cause is lack of availability of low cost housing particularly in metro areas. The sixth is the elderly and chronically phys-

ically ill and disabled, and this flows into the lack of support that we have now in the family structure in terms of following through with caring for those of our family who are elderly or mentally ill or physically disabled.

I would like to limit the remainder of my remarks now to the homeless mentally ill. I do not mean to imply by that that all the homeless are mentally ill, but that is as a psychiatrist is and has been my main interest.

Our research here as well as most of the research across the country has indicated that 30 to 50 percent of the homeless are significantly and chronically mentally ill. I am not going to outline some of the factors that have produced this. I do have them in the copy of the testimony that I have, and I will leave for you to review as our time is quite short.

But I would like to focus now on what we can do for particularly the homeless mentally ill. First of all, I do not want to paint a picture that is bleak and without hope because that is not the case. Quite the opposite is true. Over the last six years we have found new techniques and methods for reaching the homeless mentally ill, bringing them back into the mental health treatment system, back to their families and back to the communities.

The skid row mental health program which I founded in 1981 has become a model for dozens of cities across the nation and in the past year was recognized for its achievements by being awarded the American psychiatric gold achievement award for 1986.

We have found that the traditional mental health treatment approaches however usually do not work for these individuals. They are usually frightened and alienated both from society and from mental health treatment systems, and we have to set up some type of caring, outreach program and a safe environment to bring them into the treatment system and to afford them care, not only mental health care, but a caring kind of safe environment which unfortunately we do not have in very many of our systems.

I would like to just outline very quickly some principles I think that may be of help in terms of developing programs for the homeless mentally ill. First is outreach. And I think that a good example of this is that we now pay for two full time who are just in the Greyhound bus terminal at skid row in which they will find homeless mentally ill individuals particularly the newly arrived mentally ill or women, elderly and bring them directly over to our skid row mental health project before they are exposed to the ravages of homelessness and skid row.

Second, because of the fragmentation of services that the mentally ill, particularly the mentally ill homeless, do not have available to them. All of the facets that go into stabilizing their life. When we had a state mental hospital system the mentally ill, homeless, chronic were taken care of and still are the legal responsibilities of the states of this union, and we had the social carers there, the vocational rehabilitation, the mental health service.

All of these social services all blended into one. When the mental health—the community mental health system was created, these were fragmented and were split off, so we had one system caring for one part and another for another. Not only is the funding fragmented, but the coordination is. And so I think we have to bring

these back together. And that is one of the things that we have attempted to do here, and are still attempting.

I think the third thing is as I mentioned, the safe caring, friendly environment from within the greater societal areas where these people can find the safety and human comfort that is so vital a part of their care.

Fourth, is programs for the homeless mentally ill where they will accept them, in a manner they will accept them. We found that employing the homeless and the homeless mentally ill to staff these is very, very beneficial as they understand the problems and they are readily accepted by the new people coming in.

The fifth thing I think is to prioritize groups in terms of who you are going to help. It reminds me of when I was a physician in the service, and if you get onto a battlefield there is always many more people than you can help. So I think you have to target those who are the most vulnerable who you can help, and you can target those who you have the greatest chance of helping at this time.

Now, I have just listed some of those, and I am not going to go over them. But I think that that is essential to do. The sixth element is I think you have to define the phases of intervention and the program intervention points you are going to give.

Now, I here again likened it sort of to battlefield, because I think that in modern day homelessness is much like a war zone, and the three phases that I have outlined are one the emergency first aid stage which is sort of like the battalian aid station. The second is the stabilization phase which is sort of like the mass hospital, and then the third are the long range supporting programs which have to be laid into place.

I would just like to point out as has been pointed out already that without the long range solutions to these in terms of caring systems and treatment programs, the other phases are of no value whatsoever, and we find ourselves simply recyclying these chronically mental ill homeless people in and out of programs.

And unfortunately that is where a large portion of the money across the country is going for in the homeless mentally ill. The seventh point is the vocational rehabilitation, and I know that is one of the main focuses of this group.

I have yet to meet a mentally ill individual who could not or would not greatly benefit from the satisfaction of being able to work. Freud said that work was second only to love in the stability of the human mind, and I would certainly endorse this.

Unfortunately, not just with the homeless mentally ill but the chronically mentally ill we find that work is seldom offered to them and there are no real good vocational programs, at least on a governmental level, for rehabilitating vocationally the chronic mentally ill. I think what we end up doing whether it was state mental hospitals before, it is board and care facilities now. We have chronically mentally ill sit and look at the walls, or if they are fortunate enough the TV set.

They are not afforded the opportunity and the dignity of being able to work. The last things I will pass over very quickly. I think we need an evaluation system for the homeless treatment programs because sometimes we tend to fund them and let them go

on. I think we need to know what they are doing, who they are reaching and what the results are, what the long range results are.

The next thing is the tracking system for the homeless and homeless mentally ill. One of the things we found in our study and those who have worked with the homeless know there is a drifting and wandering of homeless people because they have to go from program to program.

Most of the shelters will only give them four or five days and we lose them. I just presented a paper at the American Lung Association on tuberculosis in the homeless, and I know it was shocking to me that the homeless in the United States according to the four major studies which have just been completed in the last few years indicate that there is almost a 300 times greater rate of active tuberculosis among the homeless than the general populations. 300 times not 300 percent. We found the same statistics in shelter workers. So we see that there is a vast reservoir now building of communicable diseases among the homeless.

So if we do not care for these people because of their illness we better as society because we have a public health time bomb building up in the homeless population.

I think the mental health treatment system itself is greatly underfunded not just in terms of the numbers we have to treat but in terms of the priority given it. When we compare the dollars spent per patient now with thirty years ago we find that it is markedly less. It has not kept up with such things as public safety, fire education and this type of thing.

I think that I know you gentlemen and your committees are champions on this and I hope that you are going to champion the cause of the homeless mentally ill and bring to the end what I consider a terribly shameful situation that we as a nation and a society have brought on ourselves.

I will stop there because I think that time is not going to permit me to go over any more, but I congratulate you on these hearings and I know that you gentlemen are going to champion the causes for us.

Chairman HAWKINS. Thank you; the next witness is Ms. Maxene Johnston.

[Prepared statement of Dr. Rodger Farr follows:]

STATEMENT OF TESTIMONY OF
RODGER K. FARR, M.D.

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AND
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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

FOR
THE JOINT HEARINGS IN LOS ANGELES, CALIFORNIA, MARCH 20, 1987

CONGRESSMAN AUGUSTUS HAWKINS
CHAIRMAN OF THE HOUSE COMMITTEE ON EDUCATION AND LABOR

CONGRESSMAN EDWARD ROYBAL
CHAIRMAN OF THE HOUSE OF REPRESENTATIVE SELECT COMMITTEE ON AGINGS

CONGRESSMAN MATTHEW MARTINEZ
CHAIRMAN OF THE HOUSE SUBCOMMITTEE ON EMPLOYMENT OPPORTUNITIES

Thank you for the opportunity to present testimony today on the homeless and the homeless mentally ill.

I particularly want to thank Congressmen Roybal, Hawkins, and Martinez, and the other members of the congressional committees, as well as Councilman Bernardi for their interest and concern for the homeless.

I have spent the majority of my time for the last five to six years working with the problems of the homeless and the homeless mentally ill here in Los Angeles and assisting other cities and states in trying to understand and reach out to this troubled and helpless group of people. I am certainly glad that congress has recognized the seriousness of the homeless problem that exists in the United States today and is attempting to do something about it. I do not think, we as a nation, have come to full grips with the magnitude of the homeless problem or the seriousness which it foretells to us as a nation and as a society. It is my firm belief that homelessness in America is a problem of catastrophic proportion which is the result of very serious problems in the fabric of our society.

Los Angeles has been dubbed the "homeless capital" of the nation. Somewhere between 30,000 to 50,000 homeless people within the greater Los Angeles area. While some of the homeless are natives of Los Angeles County or the state of California, many others are not bused, trucked, or flown into Los Angeles from other communities in the United States who cannot and will not deal with their homelessness. We have become the recipient for the homeless rejects from throughout the nation.

The homeless comprise a very heterogeneous group of individuals with multifaceted problems whose only common link is their homelessness. The economics of their impoverishment is only an additional compounding problem to their homelessness. It is in most cases, however, not the cause, but a symptom of their underlying inability to function in our society today. This dysfunction, in most cases is a result of an underlying root problem, such as chronic mental illness. If these root problems or causes of homelessness are not understood and addressed, there will never be any permanent solution to their homelessness. In some cases, sheltering

the homeless without simultaneous programs to resolve the root causes, may only compound and reenforce their homelessness. In the past several years, I have observed what I feel to be the "institutionalization of homelessness" going on in many large cities in the United States. Some programs are addressing only the immediate needs of the homeless in terms of sheltering and feeding them, but do not address the underlying root causes of homelessness and have tended to perpetuate homelessness. I fear we are on the threshold of creating a new "homeless industry". I am furnishing to the members of the committees copies of a research study which as the principal investigator, completed this past year. This is a two-year study on homelessness and mental illness in the Skid Row area of Los Angeles. As you will note, when you have time to review this study, we found a number of serious root causes to homelessness. Some of these causes include:

1) Serious, chronic, and incapacitating mental illness - (This comprises anywhere from 30% to 50% of the homeless population).

2) Alcohol and drug abuse problems - (This comprise approximately 40% of the homeless population. You may note that approximately 1/3 of the seriously mentally ill homeless individuals also have a drug and alcohol abuse problem in addition to their mental illness).

3) Social, cultural, and family related problems - (We found that 60% of the homeless adults have never been married, and few if any of the homeless have any lasting ties with their family and relatives. There is considerable concern on my part that the altering social patterns of the last 30 years have contributed to a breakdown in the family, both in terms of close family ties, as well as commitment on the part of family members to care for and support family members who have chronic problems or are in need of help.

4) Vocational obsolescence - (The last 30 years has seen the major shifts in the occupation and vocational opportunities afforded to the average citizen of the United States. Individuals who had marginal skills have found themselves permanently out of work through the advance technological society which has developed in the 1980's).

5) Lack of availability of low cost housing in metropolitan areas - (This problem is mostly confined to the large urban areas where housing is expensive and difficult to find).

6) The elderly and the chronically physically ill, and disabled .

I would like to confine the remainder of my remarks to the homeless mentally. Chronic mental illness constitutes the largest single root cause contributing to the chronically homeless population. Our research study, in addition to many studies which have been completed over the last several years, has verified that the mentally ill comprise a significant percent of the homeless population (between 30% and 50%). Some of the factors which have contributed to their growing numbers are:

1) The deinstitutionalization of the chronically mentally ill.

2) The inability of the community mental health treatment programs to offer consistent long-range stabilization, protection, care, and treatment.

3) Current mental health treatment laws which have allowed the patients "die with their rights".

4) Fractionalization of services for the chronically mentally ill. (example: health care, social services, mental health care, vocational rehabilitation, and drug and also rehabilitation are provided by different agencies.)

5) Underfunded mental health treatment system which has been overwhelmed by the chronically mentally ill that have been dumped out of state mental hospitals on to the communities.

6) Lack of meaningful case management, continuity of care, or lifetime planning for the chronically mentally ill.

7) Lack of support, assistance, and involvement of the families of the chronically mentally ill in the care of their family members.

8) No significant vocational rehabilitation program of the chronically mentally ill. (In spite of the fact that the vast majority can and want to work.)

9) Society appears unwilling to accept the chronically mentally ill back into the community.

<u>What can we do about the homeless mentally ill?</u>

I do not want to paint a picture that is bleak or without hope. Quite the opposite is true. Over the last six years, we have found many new techniques and methods for reaching the homeless mentally ill and bringing them back to the mental health treatment system and back to their families and to their communities. The Skid Row Mental Health Program, which I found in 1981, has become a model for dozens of cities across the nation and this past year was recognized for our pioneering efforts by being awarded the American Psychiatric Association Gold Achievement Award for 1986.

We found, however, that the traditional mental health approaches do not work for these individuals. I would refer you two articles that I have recently written for details concerning some of these techniques and approaches. They are frightened and alienated from society. They have many health problems in addition to their psychiatric problems, they are frequently victims of violent attack, and often are raped and beaten. We have found, however, that most of these people can be salvaged.

Some of the principles which we have found successful are as follows:

1) Outreach is an essential first step. Many of the homeless mentally ill are frightened and isolated and must be identified and outreach to, in order to engage them, and bring them into help. We have for example two full-time workers located in the Greyhound Bus Terminal in Skid Row, just to identify the newly arrived homeless mentally ill coming off the buses and to our Skid Row Mental Health Program.

2) Because of the fragmentation of services to the chronically mentally ill, all of the various social support programs, shelter, health care, vocational rehabilitation, mental health care, etc., must be focused to develop a unified program. We have focused team approaches involving community and private agencies.

3) A safe, caring friendly environment must be established. It is impossible to deliver any kind of mental health care to somebody who is starving, exposed to the elements, or being physically abused or victimized.

4) Programs must be located where the homeless will accept them, and stuffed by individuals who the homeless accept. Training and support of program staff is exceedingly important.

5) Prioritizing target groups. With limited available resources and funding, we are only able to help one out of five who need our assistance. Because of this, we have had to prioritize which homeless mentally ill individuals we give care to. This ensures that at least we will be able to help those who are the most vulnerable, as well as those who offer the greatest opportunity for success. Our target groups include:

    1) The newly homeless mentally ill. (More accessible to help.)

    2) Women and children. (Most vulnerable.)

    3) Those who are physically ill, as well as mentally disabled.

    4) The "dual-diagnosed" patient. (With both mental illness and drug and alcohol abuse.)

    5) The elderly homeless mentally ill.

6) Three phases of intervention for the homeless mentally ill.

The problems of the homeless mentally ill are similar to those found in the battlefield. There must be some system of intervention, care, and triage and stabilization of these individuals back into society and the community. One thing we tend to forget is that chronic mental illness is "chronic", and in most cases lifelong. The planning for their care, treatment, and support must also be lifelong. The following phases of intervention and treatment are suggested:

a) The emergency phase - ("Batallion Aid Station" - This includes the outreach, the drop-in centers, and the emergency programs located on the streets to identify the homeless mentally ill and offer immediate help.

b) The stabilization phase - ("The MASH Hospital" - During this phase the homeless mentally ill individual is simultaneously given all of the necessary physical, social, and mental health treatment and support that are necessary to stabilize their life. We have found that with this type of stabilization, the majority of these individuals can be returned to some semi-permanent or permanent community care program.

c) Long-range programs and solutions - (For a large number of the chronically mentally ill homeless, there must be some type of planned long-range care. Otherwise, we will simply be recycling the chronically mentally ill homeless in and out of our community and in and out of our mental health treatment systems. The long-range programs should include an in-depth reexamination revitalization and a reexamination of the current mental health treatment approaches, mental health treatment laws, and mental health funding this country. There is a growing feeling that some type of outpatient mandatory mental health treatment law must be developed in order to care for a substantial number of the homeless chronically mentally ill It is also true, however, that if adequate, safe, caring environments are provided, with meaningful vocational rehabilitation, as many as 50% of the homeless mentally ill could be cared for in the community without the necessity of longrange commitment procedures.

7) Vocational rehabilitation - There must be a well founded, meaningful system of vocational rehabilitation for the chronically mentally ill. I have yet to meet a mentally ill individual who could not or would not greatly benefit from the satisfaction of being able to work.

8) A meaningful system of continuing of care and case management.

9) An evaluation system for homeless mentally ill programs - We are in the phase now where funding is becominb available for the homeless mentally ill. We have seen hundreds of programs to assist them, blossom across the United States in the last two years. However, there has been very little done to evaluate the effectiveness of these treatment programs and to see exactly who they are treating and what the results of these programs are.

10) Tracking systems for the homeless and homeless mentally ill - Our experiences had been that the homeless wander a great deal and will migrate from one area to another. A tracking system can be developed for these individuals if we are to provide any consistent or meaninfful assitance.

11) The mental health treatment system in this state and in this country is greatly underfunded. It is underfunded not in terms of the massive numbers of chronically mentally ill and mentally ill homeless that need care, but also as compared to the amount of money which was previously spent on each patient in the old state hospital treatment sytem 30 years ago. Funds available for the treatment of the chronically mentally ill has significantly decreased over the last 20 years. This is particularly noticeable as compared with the funding available for education, police and the judicial system. It is my hope that the members of the congress, through the leadership of individuals such as yourselves, will champion the cause of the homeless mentally ill and will bring an end to the terrible shame we have brought upon ourselves as a nation and as a society, by allowing the chronically mentally ill to suffer and die in our streets.

12) Foster-home care and small group homes for the homeless mentally ill - After stabilization, many of the homeless mentally ill can be taken care of in small group homes or by being placed with retired couples in foster home arrangements similar to that use by the foster children program. This would provide long-range residential care, as well as providing a warm, caring environment. Foster home operators would have a close working relationship with the mental health services. An added value to this program is that it would provide additional income to many older couples on fixed incomes.

13) The Social Security Disability Program - The vast majority of the homeless mentally ill are eligible for social security disability benefits. This seems to be the only feasible long-range financial support that is available for this group of disabled people. In spite of their eligibility, our research found that only 3% of the homeless population were receiving any type of social security disability benefits. This is is particularly disturbing since we know that at least 1/3 of the homeless are severely and chronically mentally ill disabled. It is vital then to improve the accessibility of the social security disability system for these people.

I thank you very much for the opportunity to testify before your committees.

RKF:md

Enclosures

RKF86-8:15

EXECUTIVE SUMMARY

A STUDY OF HOMELESSNESS AND MENTAL ILLNESS IN THE SKID ROW AREA OF LOS ANGELES

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PROJECT ROSTER

A STUDY OF HOMELESSNESS AND MENTAL ILLNESS

IN THE SKID ROW AREA OF LOS ANGELES

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EXECUTIVE SUMMARY

In late 1983, the Los Angeles County Department of Mental Health was awarded a research grant by the National Institute of Mental Health to examine the epidemiology of mental disorders among the homeless in the Skid Row area of Los Angeles. After a start-up period of five months during which time instrumentation was developed and a sampling strategy designed, a survey of homeless individuals in the inner-city of Los Angeles was fielded. Interviewing took place between July 1984 and March 1985. The resulting data were edited, coded, keyed onto magnetic tape, placed on disk, and run against a series of cleaning programs to check for out-of-range values, and errors. Descriptive analyses of the data then took place between November 1985 and March 1986.

The survey was designed and carried out with three goals in mind: (1) to arrive at an empirically-based understanding of the inner-city homeless population; (2) to determine the proportion of individuals suffering from specific psychiatric disorders, including substance use disorders; and (3) to compare homeless individuals with severe and chronic mental illness to the homeless population as a whole on a host of demographic, social support, and lifestyle measures. Toward these ends, face-to-face interviews, ranging in duration from an hour and a half to three hours, were conducted with a sample of 379 homeless individuals in the Skid Row area of Los Angeles. In marked contrast to previous studies, this project succeeded in (1) drawing a probability sample which, as nearly as possible, represented the entire inner-city homeless population, and (2) interviewing this sampling using a standardized diagnostic instrument with known properties of validity and reliability. As a result of this methodological care, project results can

speak with more confidence on general characteristics and the epidemiology of mental disorders among this group of homeless adults.

Methods

Sampling. The objective which guided the development of our sampling plan was to recruit for the survey a sample of approximately 300 homeless persons inhabiting the downtown Skid Row area who could be considered representative of the entire homeless population in the area. For purposes of sampling, Skid Row was conceived of as consisting of four sectors of people: (1) people who avail themselves of beds, whether in missions, county vouchers for hotel rooms, or through other shelter programs; (2) people who use meal services offered by missions and other organizations; (3) people who pass through indoor congregating areas such as day centers, drop-in centers and mission chapels, either to simply get in off the street or to receive basic services; and (4) people who hang out on the streets or in well-known outdoor congregating areas. Creating a sampling frame--that is, enumerating the defined population in some way so that each person would have a known probability of being selected into the sample--proved to be increasingly difficult as we moved from the first of these sectors to the last. As a result, our sampling strategy involved first sampling those in beds, then moving on to the meals sector where we sampled only those who had not had a probability of being caught in our bed net (that is, those who use meals but not beds), and finally moving on to the congregating areas, where we sampled only those who had not had a probability of being sampled as they used beds or meal services. In this way we extended the representativeness of our sample, ensuring that it would include sufficient numbers of those who do not use beds and/or meals, while at the same time allocating the maximum possible number of interviews to the beds sector.

where there was the greatest possibility of methodological rigor (i.e. catching people who use beds while they are in beds, rather than in either of the other sectors).

The number of interviews allocated to each of the sectors was based on the results of a sampling survey designed to reveal the relative proportions of people in each of these sectors--the proportion of people found in congregating areas who use neither meal nor bed services, and the proportion of people who use meal services but do not avail themselves of beds. Likewise, interviews were allocated to facilities and locations within each sector on the basis of results from similar surveys designed to reveal (1) the number of different people who use each facility within a 30 day period, and (2) the overlap between facilities--in other words, the extent to which people use more than one facility. The number of interviews allocated to each facility, then, was proportional to the number of different people it served out of the total homeless population in Skid Row.

Interviews were not allocated to the outdoor sector because of the impossibility of creating a sampling frame in areas characterized by no real boundaries and an inordinate amount of population movement. Instead, we conducted a short survey with approximately 350 individuals in a wide range of outdoor areas, asking them questions which allowed us to determine whether they were homeless and whether they would or would not be included in our bed-meal-indoor congregating area-generated sampling frame. Fully 86% of those surveyed revealed that they had passed through our sampling frame in a 30 day period, a more than large enough figure to support our confidence in the representativeness of our sample.

In the end, the sample was drawn from the universe of Skid Row bed, meal and congregating facilities (with the exception of three which declined to

cooperate): a total of seven different locations in which people find beds, eleven different meal settings at five facilities where people are served meals, and seven different indoor congregating areas. Selection of respondents at each of the locations was random.

Measures. The mental health evaluation portion of the interview consisted of the National Institute of Mental Health Diagnostic Interview Schedule (DIS). This highly structured instrument allows trained lay interviewers to collect data which, when analyzed with a computerized scoring algorithm, produce current and lifetime diagnoses based on the diagnostic criteria of the American Psychiatric Association (DSM-III). Also included was the Center for Epidemiologic Studies Depression Scale (CES-D), a 20-item measure of current depression-related symptoms which has successfully been used as a measure of generalized psychological distress or demoralization. Non-diagnostic questions dealt with demographics, subsistence issues, health, utilization of medical services, utilization of mental health services, employment, public support, relationships with family, relationships with friends, relationships with other significant individuals, homelessness history, victimization, and patterns of mobility. When questions were borrowed from the Los Angeles Epidemiological Catchment Area (LAECA) instrument, modifications were made to render them appropriate for use with a homeless population. The majority of the non-diagnostic questions, however, were developed specifically for this study.

Results

The results offered in this report reflect preliminary analyses of the survey data. Descriptive statistics are presented on the homeless population of the inner-city area as a whole. More specifically, discussion focuses on the demographic characteristics of this sample of homeless adults, the prevalence

of mental disorders among this sample, and the wide range of social and lifestyle characteristic variables included in the non-diagnostic portion of the survey instrument. As such, this discussion addresses the first two data-related goals of this project: to arrive at an empirically-based understanding of the inner-city homeless population and to determine their mental health status. The third of the data-related goals--that of determining how severely and chronically mentally ill individuals differ from the sample as a whole--will be dealt with in a subsequent report.

Demographics. This sample of inner-city homeless individuals proved to be overwhelmingly male, somewhat young compared to the County population as a whole, and disproportionately non-white. Only 4% of this sample consisted of women, though women may have been underrepresented as a result of our having been denied access to a single Skid Row facility exclusively serving women. Mean age in this sample was 38; median age was 35. Moreover, approximately two-thirds of these homeless individuals (65.5%) fell below the age of 40. Almost three-quarters of this sample of homeless adults were minority group members: 38.6% were black; 24.9% were Hispanic; 5.1% were American Indians. Only 27.1% were white. The majority had never been married (59.1%); those who had were in virtually all cases either separated or divorced at the time of the interview. As a group they were less educated than the County population, though over half of them had at least a high school education. Approximately one-third were veterans, a figure which is consistent with the State population as a whole.

Mental health status: Prevalence rates and psychological distress. Using the DIS, it was possible to determine lifetime and current (i.e., within the last six months) prevalence rates for each of the following disorders: schizophrenia and schizophreniform disorders, affective disorders (including

mania, major depression and dysthymia), cognitive impairment (suggestive of organic brain syndrome), panic disorder, generalized anxiety disorder, antisocial personality, and substance use disorders (including alcohol abuse/dependence and drug abuse/dependence). Because the LAECA project had used the DIS as a measure of psychiatric disorder in its psychiatric epidemiologic survey of a household sample in Los Angeles, it was also possible to compare our results from an inner-city homeless sample to a community sample.

Among our sample of homeless adults in the inner-city area, rates of each of the disorders measured by the DIS were significantly higher than those of the males in the LAECA sample. (Only the males in the LAECA sample were used for comparative purposes because the homeless sample was overwhelmingly male, which made comparisons with the LAECA sample as a whole inappropriate.) Prevalence rates among the homeless were most disproportionately high in the area of major mental illnesses--schizophrenia and affective disorder. Lifetime prevalence of schizophrenic disorders in the homeless sample, for instance, was 13.7, almost 35 times higher than the males in the LAECA sample. The lifetime prevalence of bipolar disorder was 10.6 in the homeless sample, almost 18 times higher than in the household sample. While lifetime prevalence of antisocial personality and substance use disorders were quite high in the homeless sample (20.8 and 69.2 respectively), these disorders tended to be relatively high in the household sample as well (4.6 and 24.8 respectively). Thus, the rates for these disorders were only 4 and a half times higher in the case of antisocial personality and less than 3 times as high in the case of substance use disorder.

Prevalence rates drop, often dramatically, when one considers current, rather than lifetime, DIS/DSM-III diagnoses: current prevalence of substance use, for instance, was 31.2. For the most part, the relationship between

the homeless and non-homeless samples remained the same, however: it was again in the area of major mental illness that prevalence rates within the homeless sample were most disproportionately high. Indeed, if anything, the margin of difference increased. An individual in the homeless sample was 25 times more likely to have experienced a manic episode within the last six months, almost 7 times as likely to have experienced a major depressive episode and almost 8 times as likely to have experienced any affective disorder.

Because each prevalence rate is based on the number of people who met criteria for a disorder, regardless of whether they met criteria for any other disorder, the prevalence rates produced by the DIS are not additive. One cannot, in other words, simply add the prevalence rates of certain categories together in order to arrive at summary statistics. As a result, the prevalence rates do not lend themselves to answering the question which most preoccupies those concerned with the issue of mental illness and homelessness: What proportion of homeless individuals are severely and chronically mentally ill? To estimate this proportion, an operational definition of chronic mental illness based on the DIS data was developed. According to this definition, individuals were severely and chronically mentally ill if they either (1) had a diagnosis of severe cognitive impairment (organic brain syndrome); (2) had a diagnosis of schizophrenia, excluding those who had not suffered any schizophrenic symptoms within the last three years; or (3) had a diagnosis of major affective disorder, excluding those who reported single episodes only, those whose episodes did not meet DIS severity criteria, those who had not experienced an episode in the last three years, those whose depressive episodes had each taken place after someone close to them had died, and those whose only affective disorder was dysthymia. An operational definition was also arrived at for chronic substance abuse/dependence. Individuals were

included in this group if they met criteria for substance use disorder, with the exception of those who (1) had abused or been dependent on substances for a relatively short duration (a year or less); (2) had experienced no abuse/dependence symptoms within the last three years; or (3) had abused cannabis only.

Twenty-eight percent of the homeless sample met criteria for severe and chronic mental illness using the above definition. This figure underrepresents the severely and chronically mentally ill within this sample since a number of individuals who were quite possibly schizophrenic--even probably schizophrenic--either refused to answer the schizophrenia symptom questions during the DIS portion of the interview or consistently denied the presence of schizophrenic symptoms. If one adds to the category of severe and chronic mental illness those individuals whose behavior and answers to other questions (e.g. past hospitalization, receipt of SSI, past neuroleptic medication, a past diagnosis of schizophrenia) indicated probable schizophrenia, this figure would rise to almost 33%. A less conservative estimate, then, would be somewhere between 28% and 33%. These figures, it should be pointed out, are derived from a conservative definition of chronic mental illness--one which focuses on those diagnostic categories (organic brain syndrome, schizophrenia and affective disorder) which predominate among the chronically mentally ill population. It does not include other disorders measured as part of this research effort--anxiety disorders and antisocial personality disorder--which can, in and of themselves, be chronically disabling in certain cases. Finally, it does not include a host of personality disorders which we were not able to measure--disorders which can also be functionally disabling. Anecdotal evidence from service providers in the Skid Row area of Los Angeles suggests that a broadening of the definition of chronic mental illness to include these Axis II categories

would yield even higher estimates of chronic mental illness.

Slightly more than a third of this sample of homeless adults (34.2%) met criteria for chronic substance abuse in the absence of major mental illness. An additional 12% of the sample, however, had dual diagnoses of chronic substance abuse and major mental illness. (These individuals were included in the 28% of the sample discussed above.) The total percentage of chronic substance abusers, regardless of other diagnosis, was thus 46.2%--almost half of the sample. Finally, 37.8% of this sample of homeless individuals were neither chronic substance abusers nor chronically mentally ill according to the above definition.

Specific disorders aside, it was clear from the CES-D results that the vast majority of our homeless respondents were currently experiencing depressive symptoms indicative of psychological distress and demoralization. This contrasts markedly with the 9.4% of the males in the LAECA sample who were currently experiencing psychological distress. Moreover, the elevated level of distress among the homeless was not simply a function of elevated rates of current psychiatric disorder. Almost a third (32.9%) of the individuals who met criteria for current psychological distress had no current DIS/DSM-III diagnosis.

In summary, these data confirm that a significant number of homeless individuals in the inner-city of Los Angeles have serious mental health problems. Indeed, even using a conservative definition--one which focuses on those diagnostic categories which predominate among the chronically mentally ill population--as many as a third might be termed severely and chronically mentally ill. This figure might rise even higher were it to have included individuals who are so severely impaired by anxiety or personality disorders that they fall into this category as well. Interestingly, in contrast to the

findings of previous studies, affective disorders accounted for the majority of major mental illness among the chronically mentally ill in this Los Angeles sample, a difference which is difficult to assess but which may reflect differences in diagnostic procedures.

These data also make it clear that substance abuse and dependence presents serious problems for a very significant number of the homeless individuals in this sample. While the composition of the Skid Row population has changed to include increasing numbers of non-white, younger, and mentally ill individuals, substance abuse and dependence has not disappeared by any means. Much more analysis will be required before the relationship between substance use and homelessness can be determined--that is, before we know the extent to which substance abuse precedes, and in a sense, causes homelessness, and the extent to which it represents a coping strategy of individuals once they become homeless. Whatever its cause, the high prevalence of substance abuse, especially alcohol abuse/dependence, suggests the need for an increase in programs designed to help this segment of the population. Moreover, the fact that as many as 12% of the individuals in this sample have dual diagnoses of chronic mental illness and chronic substance abuse suggests the importance of special programs staffed by professionals who can treat those problems concurrently.

Finally, it should be highlighted that about 40% of this sample of homeless Skid Row residents had no chronic major mental illness or chronic substance abuse problem, and that an identical proportion had no current DIS/DSM-III diagnosis whatsoever. While some of these individuals may have chronic mental health problems not measured by the DIS, the existence of such a large percentage of individuals in this category underscores the fact that this homeless sample does include significant numbers of individuals whose homelessness cannot be accounted for by mental illness or substance abuse.

For some of these individuals, the lack of a job and opportunities to stabilize their lives are probably primary factors standing between them and a better life.

Utilization of mental health services. An examination of the inpatient experiences of this group of homeless individuals revealed that 35.5% had been hospitalized at some point in their lives for mental health, alcohol or drug problems. While this question was not asked with reference to mental health problems alone, the figure of 35.5% falls to 26.7% if those individuals who reported inpatient experiences with alcohol or drug facilities only are excluded. The majority of individuals who reported having been hospitalized had been admitted to more than one kind of facility and reported having been hospitalized several times. Of the sample as a whole, 14.8% reported having spent time in a state hospital. While these data do confirm a significant degree of past hospitalization among homeless individuals, then, they do not support the simplistic notion that the homeless are largely comprised of ex-state hospital residents.

Less than a third of the individuals admitted to inpatient facilities at some point in their lives for mental health, drug or alcohol-related problems (11.9% of the sample as a whole) had been admitted to inpatient facilities within the last year. Inpatient admissions due to substance use problems accounted for the majority of those recent admissions. Only 14 individuals--4.4% of the sample as a whole--had been admitted to hospitals over the previous year as a result of mental health problems.

As for outpatient experiences, 30% of the individuals in this sample of inner-city homeless adults reported having seen professionals on an outpatient basis because of mental health-related problems over the course of their lives. A much smaller number reported having seen professionals for substance abuse

problems in spite of the high prevalence of such problems: 6.3% in the case of alcohol-related problems and 4.7% in the case of drug-related problems, though more individuals reported contact with alcohol clinics, drug clinics and self-help groups. Of those individuals who had seen professionals on an outpatient basis for reasons related to their mental health at some point in their lives, however, less than a quarter (23.9%) had done so in the last six months. Only 8.2% of the sample as a whole, in other words, had had outpatient contact with a professional within the past six months because of mental health problems. Those who had not recently seen a professional reported that it had been three years, on the average, since their last contact. Taken together, the inpatient and outpatient experiences of this sample of homeless individuals highlight the extent to which those with serious psychiatric and substance abuse problems are not receiving the kinds of services they need.

Health and utilization of medical services. Data on health suggested that this is a group of individuals who, for the most part, neither see themselves as being particularly healthy nor enjoy good health. Almost half (48.3%) of these individuals describe themselves as being in either poor or fair health, and for almost a quarter of them (23.5%) their health either makes it difficult or impossible to get around. Over two-thirds of the sample (70.2%) reported health problems and/or accidents or injuries within the last six months, the majority of these individuals reporting more than one such problem. Indeed, 38.2% of the sample reported at least two problems and 21.6% reported three or more. One-fifth of the sample (19.7%) reported chronic problems, over two-fifths (44.2%) reported acute problems, while slightly more than one-fifth (21.0%) reported accidents or injuries.

Almost half the sample (44.8%) sought medical care for a medical problem or an accident or injury within the last six months. This figure is especially

high given the number of individuals who cited problems which they believed deserved medical attention but which had not received attention--25.4% of the sample. All in all, a picture emerges of a medically needy group of individuals who do not always have the resources to get the care they need. They tend not to have health insurance--indeed only 16.3% do--and thus cannot depend on the private sector for health care. They are thus largely dependent on (1) emergency rooms which accept indigent patients (44.2% cited the county hospital as their usual source of medical care), (2) Veteran's Administration clinics for those who qualify (10.4% cited such clinics as their usual source of medical care), and (3) free clinics in their neighborhoods, usually in missions and soup kitchens (cited by 13.6% of the sample). As many as 15.8% responded to the question, "Where do you usually go for medical care?" by saying "Nowhere."

Quality of life. Recognizing that satisfying their basic material needs is one of the greatest challenges which homeless individuals face, we included in our instrument detailed questions on where people find shelter, food, clothing, and settings in which to clean up. In addition, we sought information on the difficulty which individuals faced in trying to meet these needs. Lastly, knowing that personal safety stands as a central concern of people in Skid Row, we also sought information on the extent to which they have been victimized, their strategies for self-protection, their attitudes toward the police, and the extent of their contact with law enforcement agents and agencies.

An examination of shelter sources over the last year, the last 30 days, and the previous night revealed the central role which missions and similar programs play in the lives of these homeless individuals: 54.3% had spent at least one of the previous thirty nights in a mission or other private shelter; 44.2% had done so the previous night. The street, however, was mentioned almost as frequently by these individuals: 47.4% had spent at least one

night on the street within the last month, averaging 9.8 nights over the month; 25.6% had slept on the street the night before. Other categories were also mentioned in surprising strength: 27.7% of the sample had slept in a hotel within the last month; 20.1% had slept in an all night theater at least once within the previous month; 14.9% had spent at least one out of the last 30 nights with family or friends; 14.4% had spent at least one night in a car. A look at the number of shelter categories which individuals used over the course of a thirty day period confirmed that individuals tend to use multiple sources, rather than single sources of shelter: almost two-thirds of the sample (62.5%) spent at least one night in more than one shelter category.

As for why they did not have places of their own, the majority of these individuals cited economic factors--53.4% said they were homeless because they had no money; 48.9% indicated that they were homeless because they had no job. Substance abuse problems, health problems, welfare problems, family crises, and psychiatric problems were mentioned in much smaller numbers. (More than one mention was allowed for this question.)

Only one-third of this sample (32.2%) could count on having three meals per day. By far, the primary source of food for these homeless individuals over the previous thirty days had been missions and soup kitchens: almost two-thirds (64.4%) indicated that they had relied on these over any other food source. In terms of actual usage, 84.7% of the sampled ate at missions or soup kitchens at some point over the last 30 days; 73% had done so within the last 24 hours. Large numbers of individuals also reported using coffee shops and fast food places at least once in the last 30 days, but comparatively few had done so within the last day. Significant numbers of individuals also reported receiving food from friends or relatives within the last 30 days (30.7%), but only 6.8% had done so within the last 24 hours. Getting enough

to eat was usually or sometimes a problem for over half the sample (51.8%). The majority, however, felt that finding shelter was much more difficult than finding food.

Almost a third of this sample of homeless adults (31.2%) indicated that they did not have a mailing address. Of those who did, missions or the homes of family or friends tended to serve this function. Missions and similar organizations also played important roles in terms of supplying clothing and providing locations in which these individuals could clean up: 48.8% reported receiving their clothing from missions or drop-in centers while 66.9% reported using these settings for cleaning up.

Data pertaining to personal safety revealed that more than half (53.8%) of these inner-city homeless residents had been victimized within the past year, in the majority of cases more than once. Slightly over one-third of the sample (35.8%) had been assaulted in the last 12 months; slightly less than one-third (31.8%) had been robbed. Moreover, the vast majority of these crimes went unreported to the police--less than half of the individuals who experienced some kind of victimization reported that experience to the police (41.4%), probably because the police either cannot or will not provide help when they <u>are</u> contacted. Indeed, while these homeless individuals hold the general notion that the police can be turned to for help (67.3% thought this was the case), they pointed to only rare instances of the actual provision of such help and were far more likely to report (1) being harassed (40.8%), and (2) going out of their way to avoid the police (47.5%). Instead of relying on the police for protection, they tend to employ a series of strategies aimed at minimizing their vulnerability to victimization, such as staying away from certain places (88.6%), staying away from certain people (76.9%), making sure they are always with people they can trust (53.7%), sleeping by

day and staying up by night (24.4%), and carrying a weapon (23.7%). In addition, they count on other people in their lives for help in protecting themselves, though the high proportion of those who mention having no one (34.8%) or who mention themselves (13.9%) or God (8.2%) suggests that help from others in this regard is not always available. Finally, it is also clear that many of these homeless individuals frequently have brushes with the law: 36.1% reported having been picked up by the police within the last 12 months; 31.7% reported having spent time in jail within the last 12 months.

Employment and income. Only 5.1% of the individuals in this sample of inner-city homeless adults described their current employment status as one of "paid employment"; the majority (66%) refer to themselves as being unemployed, looking for work. Fully two-thirds (68%) reported having done some work for pay over the last 12 months, but the vast majority had not been consistently employed over that time. Instead, these individuals tended to work for short periods of time (only 23% had worked for more than six months during the past year, the median number of months being 1), often at more than one job--indeed, 42.6% of those who worked in the last year had two or more jobs during the time they worked.

Looking at the past experiences of these individuals, it is clear that they have, as a group, been capable in the past of holding steady jobs. The vast majority (76.7%) held a job for over a year at some point in their lives, and well over half (57.6%) held the same job for more than two years. For the most part, however, this period of job stability had taken place long ago: for over half of these individuals (53.4%), their longest held job ended more than 5 years before the time of the interview; for three-quarters (74.2%), their longest held job had ended three or more years before the time of the interview. Currently, they tend to be undergoing their most protracted period of

unemployment, a fact which is reflected in their income. Almost half of these individuals (43.6%) reported an annual income of less than $1000; more than three-quarters (77.4%) reported an annual income of less than $5000.

Public support benefits. Data were collected on the experiences of this sample with regard to disability benefits, social security benefits other than disability benefits, and welfare. Less than a quarter of the sample (23.7%) reported receiving disability benefits at some point in their lives; in many cases these benefits were temporary, stemming from work-related injuries. Only 8.9% of the sample as a whole reported receiving SSI over the course of their lives, in spite of the high percentage of those with chronic mental illness who should qualify for such benefits. Only 8.2% of the sample as a whole reported currently receiving some kind of disability payments. An even smaller number--3.1%--reported currently receiving social security benefits other than disability.

More than half of these individuals (58.7%) have received General Relief or some other form of welfare over the course of their lives. Only 8.8% of the sample as a whole, however, reported currently receiving such benefits. Almost two-thirds of those individuals who have never received welfare benefits (64.3%) believed that they are in need of them and the majority reported having applied, often more than once, but were thwarted by the very complicated procedures involved in securing and maintaining General Relief. Those who at some point received General Relief but were no longer receiving it--47.6% of the sample as a whole--tended to have lost their benefits relatively recently (57.9% within the last six months; 76.3% within the last year) and for a variety of reasons, most revolving around some breach in the rules governing the maintenance of their entitlement. Analysis of these data suggested the presence of one group of individuals who, after falling out of

the system, never tried to enter again, and a second group of individuals who are repeatedly in and out of the General Relief system: people who get put on penalty but apply again when they can or when their need is sufficiently great to motivate them to try again.

These data make it clear that this is not a group of individuals who are currently recieving public financial entitlements on a large scale basis. In spite of high rates of mental disability and some physical disability, only 8.2% were currently receiving disability; in spite of widespread poverty, only 8.8% were receiving General Relief. Moreover, the fact that those individuals who were currently receiving General Relief could find their way into a sample of homeless individuals suggests a safety net which is not tightly enough woven to protect its beneficiaries from homelessness over the course of a month.

Contact with family, friends, and others. Data on relationships with family suggested that these homeless individuals are not completely cut off from their families. The vast majority reported living family members of whom they were aware (92.6%) and the vast majority of these (75.8%--69.1% of the sample as a whole) reported contact with at least one of those relatives over the last twelve months. Respondents most often reported having been in touch with immediate family members, in many cases reporting contact on a monthly basis. Indeed, if one looks across all family categories, 64.1% of those who had contact with family members over the last year had seen at least one family member on a once a month basis (44.7% of the sample as a whole). Contact with family members involved the provision of food for only one-third of this group, however; a similar number received shelter in the course of visits with family. Finally, the majority of those who had contact with their family over the last year described the quality of the support they

received from these members as being high, though significant numbers provided less enthusiastic replies. Among the fifth of the sample (21.6%) who reported no contact with family over the last year, most had not seen family members for two years or more, and a very significant percentage (35.8%) had had no contact with family members for six or more years.

Data was also sought on rifts which might have taken place between these homeless individuals and individual family members. Almost half of the individuals in this sample (49.2%) reported breaks with at least one family member--that is, they no longer keep in touch with a relative they had previously kept in touch with on at least a yearly basis. Almost two-fifths (38.9%) reported breaks with an immediate family member; slightly over a quarter (26.0%) with an extended family member. Two-thirds (67.4%) reported feeling attached to their families--members in good standing; most of those who did not indicated that they had felt estranged from their families for long periods of time. In spite of the fact that the majority of these individuals reported feeling a part of their family and a member in good standing, however, 75.7% reported that other members of their family had contact with each other more frequently than the respondent had with any of them. In a sense, then, these data tell slightly different stories, depending on one's vantage point. As a group, these individuals reported a higher degree of contact with family than one often hears with regard to a homeless population. But it is also the case that a significant number of those with living family were estranged from them (approximately 25%); that there have definitely been breaks with key relatives in the case of many individuals who are not estranged from their families as a whole; and that most indicate that they do not have the kind of family contact that other members of their families do. As a group, then, this sample offers evidence that they are

perhaps not as split off from family as some would believe, but that problems do exist in the relationships which many have with family members.

As for friends, the majority of these homeless individuals (71.3%) reported contact with friends within the last 12 months. The majority of these individuals (59.9% of the sample as whole) reported contact with their friends within the past 30 days, on an average citing three friends with whom they had had such contact who live in the Los Angeles area. (This means, of course, that almost 40% of the sample as a whole, had not had contact with friends within the last 30 days.) Many individuals reported having friends they see every day (30.9%) and many noted the presence of friends in this social network whom they had known most their lives, though an equal number included in their social networks friends they had met much more recently. These homeless individuals tended not to rate the quality of their friendships as high as the quality of their family relationships: less than half of those individuals who reported contact with friends within the last 12 months were willing to say that their friends were very or extremely reliable, caring, or recipients of their confidences.

Almost one-fifth of the sample (19.7%) noted the existence of other people from whom they receive support. Acquaintances were cited most frequently; mission personnel next frequently, and public agency personnel, local business people and other benefactors least frequently. Most of these individuals (73.8%) cited more than one such individual and indicated that they tended to see these individuals frequently.

These data, then, demonstrate that the majority of these homeless individuals can cite family and friends with whom they had some kind of contact within the last year, though a noteworthy percentage (13.5%) were hard pressed to find candidates in either category, undoubtedly more than one

would find in a non-homeless sample. These numbers indicate that the potential for support exists in the case of many individuals. The qualitative feel of what respondents had to say, however, suggested relationships which were overtaxed and cloaked in all kinds of ambivalence. Interviewers walked away from the majority of interviews with the sense that the actual support that individuals could count on from family and friends was distressingly negligible. More research, including research of a qualitative nature, is necessary in this area if we are to learn what the support systems of homeless individuals are like and how they are used.

Exposure to Skid Row and history of homelessness. For the vast majority of these individuals, Skid Row was not a new place--72.9% had first experienced a Skid Row area at least a year earlier; 63.4% had first experienced a Skid Row area 2 or more years earlier. In most cases (74.7% of those who indicated that they had lived in a Skid Row area), their first experience in a Skid Row area had been Los Angeles. Not all of these individuals, however, had been on Skid Row continuously since their first experience in such an area: almost three-fifths (58.1%) had, since their first time, spent time in non-Skid Row areas. Most of the individuals who had spent time in non-Skid Row areas (80.4%), in fact, had enjoyed periods of stability during their time away from Skid Row, often more than once (64.9%) and for an average of a year, during which they had their own places and/or jobs. Indeed, almost half the sample as a whole (46.7%) reported such experiences, and over a quarter (28.7%) reported having such experiences more than once. For most, however, their longest period of stability was not a recent one: only 21.1% of the sample as a whole reported their longest such period ending within the last year.

As with first episode on Skid Row, first episode tended to have taken place well into the past: 68.3% of this sample indicated that it had been

two years or longer since their first episode of homelessness; 43.6% indicated that it had been more than 5 years ago. Only 15.1% indicated that it had been less than a year since their first episode of homelessness. Of those who admitted to being homeless, almost two-thirds (63.5%) indicated that they had first become homeless in Los Angeles. As for their stated reasons for becoming homeless the first time, economic factors were mentioned most frequently (42%). Leaving home, usually because of some kind of family crisis, was offered next most frequently (18.9%).

Looking at the experiences of these individuals since they first became homeless, it became clear that a relatively small percentage of these inner-city homeless residents (17.8%) were newly homeless and that a similarly small percentage (14.8%) had been continuously homeless for a year or more (i.e. homeless for period uninterrupted by stays with family, friends, or a place of one's own for a month or more). For the majority of these individuals (67.4%), however, homelessness was episodic. Since the first time they were homeless, these individuals <u>had</u> experienced stability during which they managed to pay rent on their own places or stay with family or friends, but found themselves homeless again. In fact, many of them have experienced such periods of stability often. Life, for these individuals, has been cyclical since they first became homeless, alternating back and forth between periods of homelessness and periods of stability.

<u>Wandering and mobility.</u> Close to two-thirds (64.5%) of these inner-city homeless individuals had lived in Los Anyeles for more than a year. More than half (55.3%) had lived in Los Angeles for more than two years, while 43% had lived in Los Angeles for over five. Only 27.5% had lived in Los Angeles for six months or less. As such, this Los Angeles homeless sample appeared to be no more transient or migratory than samples drawn in other cities and

states (e.g. St. Louis and Ohio).

Other measures of transience included the number of times respondents lived in Los Angeles, the number of moves they made in the last five years, and the number of moves they made in the last year. Over half the sample reported living in Los Angeles more than once over the course of their lives (53.3%), though 69% reported living in Los Angeles no more than twice, suggesting that for the most part this is not a group of individuals migrating in and out on a regular basis. Over three-fifths (71.2%) have made at least one move from city to city within the last 5 years, though over half (52.4%) have made no more than two moves in that period of time. Half the sample (50.7%) reported no moves from city to city within the last year; 71.1% reported no more than one. A third (33.8%) indicated that they were considering a move from Los Angeles in the near future.

With regard to intra-city mobility, the data suggest that while a small number of individuals in this sample of inner-city homeless adults did not regularly sleep in the downtown area, the overwhelming majority (86.5%) did. Of those that did, approximately one-third (37.5%) moved into other areas on occasion--indeed, in many cases as recently as within the last week--though usually only into one such area. They tend to return to the downtown area, however, as witnessed in the very few number of days which people reported spending outside of the downtown area and in the fact that they referred to the downtown area as their main sleeping place. Only 12 individuals in the sample as a whole--less than 4%--indicated that they had never slept in the downtown area; most of the individuals who did not cite the downtown area as their major sleeping place did spend at least some of their nights there. Intra-city mobility in this sample of homeless adults, then, is <u>not</u> high. While some individuals occasionally leave the downtown area, and a very small

number may have entered the downtown area simply to receive certain kinds of services offered there, most spend the vast majority of their time in the inner-city.

Conclusions

Concluding statements highlighted the need for explanatory models incorporating structural antecedents (social policy, economic factors, housing trends) and individual factors (physical handicap, substance abuse, mental handicap), for both are critical in accounting for the existence of widespread homelessness and in explaining why certain individuals are more vulnerable to becoming homeless than others.

As for the data themselves, the heterogeneity of this sample of inner-city homeless adults--the diversity of their backgrounds and experiences--was stressed. This was not a group of individuals who had all reached Skid Row by the same route or for the same reasons. Rather, this was a group consisting of many different kinds of people whose present condition reflected a myriad of contributing factors.

The one factor which bound this diverse amalgam of people into a single group was their lack of a home and their difficulty in meeting other basic subsistence needs. For these individuals, obtaining beds, getting themselves fed, and cleaning up was often a full-time job in and of itself. Access to shelter and other kinds of help in meeting their subsistence needs was thus emphasized as a primary first step in trying to help them.

The significant proportion of individuals with severe and chronic mental illness was next highlighted. While the special experience of these individuals remains to be analyzed, data on utilization of mental health services was cited as clear evidence that they are vastly underserved by the mental health treatment system. Resistance of homeless mentally ill individuals to treatment

was rejected as the primary cause of their lack of mental health care; rather, the inability of present services to meet the enormous demand in the Skid Row area was underscored. The significant number of individuals with dual diagnoses of chronic mental illness and chronic substance abuse was also emphasized, as was the need for collaborative efforts on the part of agencies responsible for these two problems, both on a Federal and local level.

The existence of substance abuse as a serious problem for many of these homeless individuals was likewise stressed. This finding was offered not to fuel the fires of those who would dismiss the homeless in the downtown area of Los Angeles as alcoholic bums who are themselves responsible for their misery but rather to indicate the need for agencies mandated to deal with alcohol and drug rehabilitation to play a more central role in providing services to this segment of the homeless population.

Finally, it was emphasized that for almost two-fifths of this sample, neither a major mental illness nor chronic substance abuse were found. For these individuals, many of whom are truly desirous of finding work and who are capable of working but find themselves trapped in a vicious cycle which perpetuates their homelessness, different kinds of help are needed: medical care, job training and job finding programs, vocational rehabilitation, and assistance which would allow them to put their energies toward work, rather than towards subsistence and/or maintaining public support payments.

58

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BILLY E. JONES, M.D.

64

5

A Mental Health Treatment Program for the Homeless Mentally Ill in the Los Angeles Skid Row Area

Recently a great deal of media attention has focused on the increasing number of homeless people in America. The problem has received much publicity, but very little has been done to try to understand the causes of homelessness or to devise ways to help this suffering segment of our population. The phenomenon of homelessness in America is not limited to the decaying areas of our large cities, but is a nationwide problem of grave national importance.

Until recently, most people thought the homeless "skid row" residents, or street people, were men and women who were either chronic alcoholics, derelicts, or dropouts from society who simply did not desire to better themselves. They were seen by our society as people who deviated so far from the American work ethic as to be not worth helping; however, this is not the case (1).

The Los Angeles Skid Row Area

The Los Angeles Skid Row area covers approximately two square miles in the heart of downtown metropolitan Los Angeles. With a perimeter formed by freeways and the Los Angeles River, its boundaries are more psychological than physical. Rundown busi-

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nesses, cockroach-infested hotels, railroad tracks, bridges, and numerous bars and liquor stores characterize its landscape. Although there are many private missions and shelters offering thousands of free meals a day and 1,800 free beds a night for those lucky enough to obtain them, most of the thousands of homeless residents end up sleeping in abandoned buildings, alleyways, garbage bins, under bridges, and so forth.

THE LOS ANGELES SKID ROW POPULATION

The population of the Los Angeles Skid Row area has changed markedly over the last 15 years. Previously it had been populated primarily by older men with a high proportion of chronic alcohol or drug abuse problems. In recent years, it has been invaded by large numbers of young chronically mentally ill men and women.

Deinstitutionalization

This change in population parallels the deinstitutionalization of the state mental hospital system in the United States over the past 20 years. We found significant numbers of homeless people in the Skid Row area who had previously been hospitalized in a mental hospital, as other investigators are now finding (2). Our work indicates that a large percentage (approximately 30 to 50 percent) of the hardcore homeless population of Skid Row are chronically and seriously mentally ill (3). They are not the winos or derelicts of the past but are often men and women from middle-class families who have experienced chronic mental illness and because of their mental disability, have been unable to make it on their own. They have trouble providing themselves with the basic necessities of life, such as food, shelter, and clothing.

For the purposes of this study, our definition of a homeless person is someone who spends a significant part of each year without shelter. Some of the homeless Skid Row residents receive County General Relief, which is about $228 per month, but more

often than not, they find themselves on the street when their money runs out before the end of the month. Many homeless are unable or unwilling to apply for public assistance.

Demographics of Skid Row Homeless

The Skid Row population varies in number depending upon the time of year and the weather. We estimate that there are seven to 15 thousand homeless people inhabiting the area. During the winter months the number of homeless in Los Angeles can double. Because of cold weather in other parts of the country, the homeless migrate to Southern California. The street people refer to these migrating winter residents as "sun birds."

The recent recession aggravated, but did not cause, the homeless problem. When we began our work in January 1981, there were already an estimated 7,000 to 10,000 homeless people in the Skid Row area, and the recession of 1982 had not yet hit. According to the staff of the missions in Skid Row, the number of homeless mentally ill had been increasing during the 10 years prior to 1981, apparently in direct proportion to the closing of the state mental hospitals.

Our work in the Skid Row area in 1981 indicated that the Skid Row population contained approximately 80 to 85 percent men, 10 percent women, and five to 10 percent children. Women and children were seldom seen in the Skid Row area 15 years ago, but their numbers have risen rapidly in recent years, and there are now an estimated 1,000 women. The Skid Row male population is approximately 50 to 60 percent black, 20 percent hispanic, 20 percent white, and 5 percent American Indian, and the female population is 60 to 70 percent white, 20 percent black, and 15 to 20 percent hispanic.

What is significant is that almost 50 percent of the homeless Skid Row population suffer from some chronic, incapacitating mental illness. Our work shows that 30 to 40 percent of the male population of Skid Row suffer from a serious mental illness, while approximately 80 percent of the female homeless population suf-

fers from a serious mental disability. A large number of those who are chronically mentally ill are overtly psychotic. We estimate that 75 percent of the psychotically mentally ill suffer from schizophrenia. Other recent studies across the nation have shown significant numbers of mentally ill among their homeless populations (4–6). We are currently completing an "Epidemiologic Research Study of the Homeless Mentally Ill in Skid Row," funded by the National Institute of Mental Health, and will soon have more definitive information concerning this population.

Acceptance Attracts Them to Skid Row

One of the main attractions of Skid Row to the chronically mentally ill is that they feel accepted there. Unfortunately, there are other attractions as well, such as alcohol, drugs, and violence. As a result, many of the mentally ill become involved with drugs, alcohol, or become victims of violence, all of which gravely aggravate their mental illness. Our work indicates that 40 percent of the mentally ill male population of Skid Row have a serious alcohol or drug problem, while only 15 to 20 percent of the female population have a serious alcohol or drug problem.

Greyhound Therapy

Many of the mentally ill homeless display behavior so bizarre as to make them socially unacceptable in the communities from which they come. In Skid Row, on the other hand, their behavior is tolerated. Many have spent time in mental institutions before coming to Skid Row. It is thus not uncommon to find persons who have been given "one-way bus tickets" out of their communities. "Greyhound Therapy" is one method some communities are using to deal with their chronically mentally ill (7). The Los Angeles Metropolitan Bus Terminal lies in the heart of Skid Row, and when mentally ill people arrive by bus, they simply lack the ability or coping stamina to get out of Skid Row.

THE PROBLEMS OF THE HOMELESS MENTALLY ILL

Destitute, Desperate, and Without Families

The majority of the homeless mentally ill are destitute. They are without adequate food or shelter and literally eat garbage and sleep in the streets. They are usually without family ties and have poor job histories. They are easily victimized by unscrupulous merchants and marauding gangs of hoodlums. Rape, assault, robbery, and even murder are commonplace daily events in Skid Row. The homeless have learned to be especially cautious on the days of the month when the General Relief or SSI disability checks are due, when roving gangs of hoodlums come to prey. The dangers of living in the Skid Row area are enormous, but for many, the dangers seem to be outweighed by the degree of freedom they experience and the tolerance for their abnormal behavior.

Inability to Utilize Traditional Services

The homeless chronically mentally ill are unable to utilize many of the traditional social support services because of the nature of their chronic mental illness, their fear of government agencies, and the inaccessibility of the programs.

Fear of Government

They are so frightened of authority figures that some seldom venture out of the Skid Row area, even to seek food or medical care. For many, prior contacts with authority figures and mental health professionals have led to imprisonment or institutionalization. They do not trust the system, some with good reason.

Independent Nature

Many of the homeless mentally ill are unable to live in a structured community environment. Their mental illness keeps them from enjoying the human contact and companionship

which they so desperately need, and their independent nature also isolates them. Many cannot handle money properly and may give it away.

Medical Problems

Their inability to seek medical care, combined with the physically unsanitary manner in which they live, frequently leads to serious health problems. The medical problems we have seen in the homeless mentally ill population are at times devastating and are more characteristic of the populations of underdeveloped countries than of America.

Rejection of the Mental Health System

Periodically many of the homeless mentally ill will spend time in an acute psychiatric hospital. They are hospitalized only when their behavior becomes so unacceptable that the police are forced to pick them up. We found that the vast majority would rather live in filth and be subjected to beatings and violence than to be institutionalized, even in our finest mental hospitals. This is a stunning indictment of our mental health treatment system and is indicative of our inability to understand or to help this segment of the mentally ill population.

Lack of Services

We found a lack of government health and social support services in the Skid Row area. The main government presence is represented by the Department of Public Social Services (DPSS) and the police. There are few health facilities in the area, and before the development of the Skid Row Project, the nearest mental health facility was five miles away.

The Children of Skid Row

In recent years, an increasing number of undocumented, Spanish-speaking women and children have migrated into Skid

Row. Many are in the United States illegally and therefore are unable to utilize traditional social, medical, and mental health treatment systems. Many are undocumented Hispanic women who work for extremely low wages in the garment industry located in the Skid Row area. In a recent survey, approximately 1,200 children were found living in Skid Row, with an estimated 80 to 90 percent being undocumented hispanic children and 70 percent under the age of eight. These children suffer from a different set of mental health problems than the homeless adults. Their mental health problems are frequently the result of "cultural shock," sexual molestation, child abuse, and exposure to the very real physical dangers in Skid Row. The children of Skid Row, like the adults, are trapped there and lack the ability or resources to leave.

THE DEVELOPMENT OF THE SKID ROW MENTAL HEALTH PROJECT

DPSS Personnel Problem

The homeless mentally ill problem in the Los Angeles Skid Row area came to light somewhat by accident in January 1981 (3). A request for help from the County DPSS triggered an investigation that eventually led to the establishment of the Skid Row Project. DPSS had been experiencing serious personnel problems with their staff in the Civic Center District Office (Skid Row). These problems finally culminated with the stabbing death of a much loved DPSS worker in December 1980. As a result of a request for help, in January 1981 the author was sent by the Department of Mental Health to assist the DPSS workers in Skid Row and to assess the mental health problems present there.

Grave Mental Health Problems

It was apparent that the mental health problems that existed in Skid Row were grave and of a far greater magnitude than had previously been suspected. Increasing numbers of DPSS workers

were becoming frightened, frustrated, and intimidated because of the overwhelming number of seriously mentally ill people they were seeing. There was a grave need to establish a permanent mental health service in the area, but because of severe financial cutbacks in funding to the Department of Mental Health, it was apparent that there would not be significant resources available for developing a new community mental health center in Skid Row. The situation was desperate, however, and some type of mental health assistance had to be developed.

The Beginning of the Project

By the spring of 1981, the Skid Row Mental Health Project had been organized, and a number of ongoing mental health programs were in operation. A weekly mental health consultation clinic was arranged for the DPSS staff, enabling them to review cases with a mental health professional and to review their own reactions to their mentally ill clients. Eventually the consultation clinic was available on a daily basis with a mental health professional stationed in the DPSS office. Regular mental health educational seminars were arranged to give the DPSS staff a better understanding of the mental illnesses they were seeing in their clients and to assist them in dealing more effectively with these clients. These programs significantly helped to reduce the stress and frustration of the DPSS staff, tensions decreased, and disagreements became less common. The very presence of a mental health professional on a regular daily basis in the DPSS office served as an important factor in quieting some of the fears and concerns of the DPSS staff.

Mental Health Problems Were Widespread

As the work progressed, it became clear that a large portion of the population of Skid Row was suffering from severe mental illness and was unable to reach out for help because they lacked the ability to engage the existing social, health, and mental health systems.

By July 1981, a full-time mental health professional was added to manage the day-to-day operations of the Project. The staff of the early Skid Row Project was comprised of the author (on a part-time basis), a small number of student and volunteer mental health professionals, and a very dedicated DPSS social worker. The Project, initially housed in the DPSS office, was born out of a team effort between DPSS and the Department of Mental Health. This team effort, which continues today, is absolutely vital in order to address the multifaceted problems of the homeless mentally ill, who urgently require social services, including food and shelter and mental health services.

Project Grew in Size

By the fall of 1981, an additional full-time psychiatrist had been added to the Project. By the winter of 1981/82, mental health outreach and consultation programs to many of the missions and shelters in Skid Row had been added. By the fall of 1983, the Project had grown to a staff of eight mental health professionals with clerical support staff, and offered a wide variety of innovative mental health programs, including extensive outreach and community consulting programs and a daily 8:30-to-5:00 mental health treatment clinic, which was located in a large Skid Row shelter.

GOALS OF THE SKID ROW PROJECT

Early Goals

One of the early goals of the Project was to survey and evaluate the community resources available within the Skid Row area. This survey revealed that there were numerous private missions, agencies, and self-help groups operating in the Skid Row area. Together, these organizations offered a formidable amount of resources and assistance to the homeless Skid Row residents. These private agencies traditionally had grown out of religious or community groups that had formed missions in response to the cries of

the helpless and wretched. Although these missions addressed the physical (food and shelter) and spiritual needs of the inhabitants of Skid Row, their staffs had little or no mental health training or understanding, and in recent years they had felt overwhelmed by the increasing number of mentally ill residents. The Project established regular mental health consultation services to the staffs of these missions and agencies.

Mental Health Patch

The Project provided a "mental health patch" for the existing programs of the missions and agencies in Skid Row, consisting of mental health consultation, education, emergency crisis intervention, and a system of referral linkages.

Mission Staff Provides Unique Care

It was found that the staff members of many of the missions were eventually able to provide a unique treatment service that professional mental health workers could not provide. Many of the staff members of the Skid Row missions were "graduates of the streets" and thus were accepted and trusted by the Skid Row residents, including the homeless mentally ill. Because of the unique treatment service offered by the mission staff, the professional mental health staff of the Project were given a rare opportunity to reach an otherwise untrusting and unreachable population. This unique partnership has been essential in the work of the Project.

The Development of Concerned Agencies of Metropolitan Los Angeles (CAMLA)

Early in our work with the missions and agencies in Skid Row, we noted an interesting problem—although many of the missions had been operating for 30 years or more within a few blocks of each other, there had been very little ongoing communication among them. They were able to recognize the fragmentation of

services and lack of coordination and communication, and we assisted them in the development of a community organization, a "coalition" of agencies, missions, and people working together. This organization is called "CAMLA" (Concerned Agencies of Metropolitan Los Angeles). The formation of CAMLA in early 1981 served as a spark to unite the various organizations in Skid Row into what has become a true community support network. CAMLA has subsequently grown into a viable, well-structured organization with a membership of over 55 different agencies and groups. In 1983, CAMLA was incorporated as a private, nonprofit corporation and has an office in a major shelter building. CAMLA is expanding its goals to include transportation services and information and referral and will continue to act as a common voice for the Skid Row community. Although the early development of CAMLA was heavily influenced by the Department of Mental Health, it rapidly assumed a life and direction of its own and now stands as an independent community organization. Greater understanding between governmental and private agencies in Skid Row, resulting from the development of CAMLA, has markedly improved and increased utilization of services by the homeless.

The Skid Row Directory

Recognizing the need for a directory of services and resources available in the Skid Row area, the Department of Mental Health together with CAMLA developed and prepared a 100-page *Directory of Services in the Skid Row Area*. The Directory was prepared in a binder, permitting constant updating and revisions as new resources and agencies were added. It listed each of the private and public agencies, the services that they provided in the Skid Row area, and the name of a key contact person within each agency. It was cross-indexed alphabetically and by type of service offered. Four hundred directories were printed and distributed. The cost of printing was covered by a private donation by a local organization. A small, eight-page pocket version of the Skid Row Directory, which lists vital services and resources and includes directions for easy use, was prepared by the Department of Mental Health and

CAMLA. We hope to have 15,000 copies printed and distributed to the residents of Skid Row. An interesting side benefit was a strengthening of the bonds and relationships among the agencies and organizations that worked together to prepare the directory.

Direct Treatment Service Added

Early goals of the Skid Row Project were to provide mental health consultation, education, emergency crisis management, and evaluation and referral. In addition, some direct treatment services were provided, and these direct services have been greatly expanded in the past two years. They are primarily geared to crisis handling, mental health evaluation, individual and group therapy, medication management, vocational rehabilitation, and mental health evaluations to establish eligibility for various disability programs, such as the federal Social Security Disability Program.

The SSI Clinic

Significant numbers of homeless mentally ill persons are mentally disabled and are eligible for assistance under the Social Security Disability Program, but they do not apply. Many are so severely mentally dysfunctional that they would meet even the most stringent criteria for eligibility under the current Social Security disability guidelines. Paradoxically, however, because of their severe mental symptoms, they are unable to follow the very difficult bureaucratic procedures necessary to gain access to the Social Security Disability Program. The Project established a daily "SSI Clinic" to assist mentally disabled homeless persons in gaining access to the federal SSI Disability Program. Strategies and procedures were developed to provide these persons with appropriate psychiatric evaluations. In order to assist these persons through the long and arduous SSI application and appeals process, it is necessary to assume a kindly and supportive advocacy role. The Project works closely with several community legal advocacy groups on the SSI program. The success rate of persons accepted into the SSI Clinic Program has been greatly increased by the SSI Clinic.

Fiscally, the SSI Clinic has proven to be quite sound. Mentally disabled persons who receive Los Angeles County General Relief support are paid an average of $228 per month. We estimate that for every 400 persons who are converted from General Relief to SSI support, Los Angeles County saves over $1 million in tax revenues each year. This does not include the additional savings to the county resulting from the fewer DPSS personnel that are needed to manage the General Relief Program once these people are removed from the General Relief role. Once these people are accepted into the SSI Program, they receive approximately $425 per month (that is almost double the General Relief support) and are then eligible for a variety of medical and mental health treatment programs under state and federal coverage. Providing assistance in entering the SSI Disability Program has become, in and of itself, an important and significant mental health treatment process for the homeless mentally disabled. The SSI Program appears to be one of the few long-range assistance programs for the mentally disabled.

Treatment Programs Must Be Innovative and Responsive

Traditional mental health treatment approaches usually are not effective in reaching or treating homeless mentally ill persons. A mental health treatment program for the homeless mentally ill should include some stabilization of their immediate physical environment, the provision of shelter, food, and physical health care, and protection from violence—all significant aspects of the mental health treatment process. It is very difficult to help these people without first establishing rapport and trust. We were able to establish the necessary trust through our close relationships and linkages with the existing Skid Row missions and agencies. It is necessary to deliver the type of mental health care that these persons can accept and in a location where they will accept it. Often this means establishing and delivering mental health services in missions and agencies. Some of the outreach and mental health programs that the Project has developed are unique and somewhat unorthodox. Some of our most successful programs

have been "piggy-backed" or "patched" onto existing programs in missions and agencies.

Drop-In Rap Sessions

Ongoing weekly group therapy programs were conducted in the missions. The term group therapy, in the traditional sense, does not apply to these groups. We refer to them as "drop-in rap sessions." There were no formal requirements for participants as any attempt to force them to follow traditional bureaucratic procedures, especially the securing of their last name, could frighten them. Pressing bureaucratic requirements and regulations on them only resulted in their leaving the program. Mental health professionals must learn to live with this type of loose arrangement and limited goal setting in order to be of assistance to this unique group. The goals of the weekly "rap sessions" were to help the members understand their mental illness and mental health treatment methods and approaches and then to link them with existing mental health treatment programs. Another goal of the rap sessions was to instruct members on how to survive in Skid Row.

The Need for a Sense of Belonging

One rap session for women was held in a day care center for homeless women. This center was founded and run by a compassionate woman who was a former DPSS worker who had noted the increasing number of destitute women in Skid Row. This center, located in what was once a dilapidated storefront, has operated for over six years and is run entirely on private donations. It assists up to 500 women per year, but many must be turned away because of the large number of women in Skid Row. Unfortunately, the center is open only during the day and does not offer beds for the women. It does provide them with a vital sense of belonging and caring—something they have rarely experienced because of their life styles and their chronic mental problems. The women cook their meals together, celebrate birthdays and holi-

days together, and find a safe refuge in the center from the frightening and hostile world they see outside. This sense of belonging and sharing offers a unique mental health treatment to these women. The goal of the Skid Row Project was to provide a mental health "patch" to the center's existing mental health program. In later years, the center was able to develop professional mental health treatment services privately on its own.

Mental Health Facilitator

The physical presence of the Skid Row Project has in itself been of great value as a sign of support and concern to the residents and agencies of Skid Row. The Project has acted as a "mental health facilitator" and has served as a vital missing link between these agencies and the mental health treatment system.

Rapid Transit District (RTD) Clinic

The lack of low-cost transportation in the Skid Row area has been a major problem to the residents, hindering their attempts to secure employment, housing, medical care, and vocational rehabilitation. The Skid Row Project developed the "RTD Clinic" (Rapid Transit District) to assist Skid Row residents in obtaining special low-cost RTD bus passes. The RTD pass is easily obtained by completing a simple form that certifies that one is transportationally disabled. Then a bus pass can be obtained for $4 per month, whereas a regular pass costs about $30 per month—a sum which is beyond the reach of many Ski Row residents. With the RTD pass, one can travel anywhere within the greater Los Angeles area.

The pass has thus become a passport for the residents and an important mental health treatment tool. It enables them to escape from the hell of Skid Row and seek employment, housing, medical care, and other previously unobtainable opportunities. Many of the residents were willing to accept medical care from a private medical facility but would not accept care from a government

medical facility. In an attempt to make medical care available to the Skid Row residents, the Skid Row Project developed a liaison with a primary care center in a local private hospital. Skid Row residents could then travel to the front door of this primary care center using their RTD passes.

Work Projects and Vocational Rehabilitation

Another serious problem among the homeless mentally ill is the lack of availability of vocational rehabilitation or employment counseling. The Skid Row Project has been working with the Los Angeles County DPSS to develop work projects for the homeless mentally ill. We found that under a little-used county regulation, persons who receive General Relief assistance from the county must be given an opportunity for employment through county work projects at various county facilities, such as gardens, offices, parks, and recreation areas. There are over 100 locations available, and we feel that these work projects will serve as an extremely valuable vocational rehabilitation tool. Work, even on a very limited basis, will raise the self-esteem and confidence of the homeless. We are also working with private and state vocational rehabilitation agencies to develop transitional work therapy projects for Skid Row inhabitants. Vocational rehabilitation and work, however limited in scope, are vital long-range goals for any permanent resolution of the homeless cycle.

The Police in Skid Row

When we first began our work, we noted that there was a lack of understanding and relationship between the police and many of the agencies serving the Skid Row area. The Skid Row Project, together with CAMLA, has developed an excellent working relationship with the police. A police department representative is a member of CAMLA and has participated in the "rap sessions." As a result of this cooperation, we have found that the police now have a better understanding of the mental health problems of

residents and do a much better job of handling them. The severely mentally ill can and must be directed into mental health treatment programs, not incarcerated in jails.

Revolving Door Syndrome

A continuing problem noted among the mentally ill in Skid Row is the "revolving door syndrome." The syndrome is not unique to the homeless mentally ill, but is common to all the chronically mentally ill. It is characterized by multiple short periods of psychiatric hospitalization with little follow-up or continuity of care between these periods. The Project is attempting to develop a community support system base for the homeless mentally ill as an alternative to costly repeated hospitalizations. We believe a stabilization center in the Skid Row area could provide support, companionship, and caring during a short period of intensive mental health treatment. An ideal stabilization center should provide a period of five to seven days of living in the center in which the homeless mentally ill not only would receive intensive mental health care but also would be "cleaned up, rested up," and given appropriate medical care, social services, vocational evaluation, and linked with the various public and private agencies that would give the additional vital care and support needed for a more long-range resolution of their problems. We envision the stabilization center as a joint public sector–private sector endeavor, operating out of one of the shelters. The price of such a stabilization center and community support program would be paid for many times over by the savings through decreased utilization of psychiatric hospitalization, emergency-room care, jail detention, and the like.

Self-Help Groups

We are in the process of developing a Skid Row chapter of a local self-help group for the mentally ill. Self-help groups can offer the long-range support and caring vital to the recovery of the chronically mentally ill. The chapters existing outside Skid Row would offer a bridge once a person was ready to move.

Recent Expansion of Service

The program has grown enormously over the last four years, currently has a staff of 24, and occupies 4,250 square feet of space located in a homeless shelter in the middle of the Skid Row area with an annual budget of approximately $800,000. It offers a wide variety of mental health treatment programs now helping hundreds of the homeless mentally ill. Some of these treatment programs include:

1. Outreach and early identification of the homeless mentally ill in Skid Row
2. Regular mental health consultation to homeless shelter and agency staffs
3. Psychiatric evaluation for SSI and other disability programs
4. Advocacy and assistance for homeless mentally ill to gain access to health and social services programs
5. Group therapy and "drop-in rap sessions"
6. Crisis evaluation and management
7. Outpatient treatment
8. Medication treatment and monitoring
9. Day-care program
10. Psychosocialization programs
11. Vocational program
12. Self-help and support group meetings
13. Case management
14. Money management (in association with the Social Security Administration)
15. Seven-day-a-week drop-in center, available to anyone who needs help
16. Certification of individuals for low-cost transportation passes (RTD clinic)
17. Priority programs targeted especially for homeless women, children, and those who are the most vulnerable
18. Facilitating and advocacy for the homeless mentally ill
19. Assisting patients into placement in long-range care and residential facilities when appropriate

20. Triage to acute psychiatric hospitalization when necessary
21. Operation of joint programs with drug and alcohol rehabilitative agencies

Private Business Involvement

The Skid Row Project has encouraged the involvement of the private sector. For example, a large donut chain daily donates to the Project a large quantity of fresh donuts, which serve as a valuable aid in attracting hungry persons off the streets to become initially involved in the Project programs. The Project has negotiated with a large aerospace firm to donate the services of alcohol and drug abuse counselors on a regular basis.

Cost of the Project

The overall cost of the Skid Row Project has been low, considering the results of the program and the numbers served. The cost for the Project was initially defrayed, in part, by the fact that the office space used by the Project was often provided free of cost by the missions and agencies it served. These agencies felt that the mental health support and services they received more than compensated them for the free office space they provided. The initial office equipment and furniture used by the Project was salvaged from discarded county furniture or provided through charitable gifts. The offices were initially refurbished and painted by Department of Mental Health employees who volunteered their services after working hours. The use of "volunteer professional staff" is encouraged and the experience has proven valuable to the volunteer professionals. We currently have social work interns, psychology interns, and psychiatric residents from the local universities working at the Project.

PROGRAMMATIC GOALS IN PLANNING FOR THE HOMELESS MENTALLY ILL

Los Angeles County has recently been named the "Homeless

Capital of the United States." The result of a study released in the spring of 1984 by the U.S. Department of Housing and Urban Development (HUD) estimates that there are between 30,000 and 35,000 homeless people in Los Angeles County. Although most of the attention has been focused on the homeless mentally ill in Skid Row, the situation is a county-wide one. The Skid Row area contains the largest single concentration of the homeless, an average of 10 thousand, but there are at least 11 other areas of concentrated groupings of the homeless in Los Angeles County (8). In addition, there is a diffuse infiltration of homeless persons throughout the entire county. They tend to seek out areas such as isolated neighborhoods and small shopping centers where there is less chance of being harmed, and the pickings of food in the garbage cans is better.

Some of the homeless mentally ill in Los Angeles are very mobile and tend to wander from one area to another—from outlying areas into Skid Row and back again. Any systematic or effective approach to help this population as a whole must be on a county-wide or regional basis in order to have any significant or lasting effect. It is vital to remember that long-range solutions must be included in any planning approach. In the past, the mental health treatment programs for the homeless mentally ill have been more of a "bandaid" type of approach, with few long-range solutions. The dollars and other resources spent over the lifetime of these persons to "put out fires" is wasted and does little to bring about any resolution to the problem or to provide long-range help or stability for them.

As outlined in "A Programmatic View of the Homeless Mentally Ill," (8) two basic approaches should be considered in planning for mental health care for the homeless mentally ill: the target groups approach and the phased intervention approach.

The Target Groups Approach

Given the present limited resources of the public mental health treatment system and the large numbers of homeless mentally ill, consideration must be given to selecting target groups from within

the general homeless population. It is very difficult to be selective, because all of those suffering deserve the opportunity to receive help. However, with current resources so limited and the need so great, if one does not single out target groups, one can soon become overwhelmed, and no one will receive any assistance.

Selection of specific target groups should be made with several principles in mind: which groups are more acutely at risk, which groups are more amenable to treatment, and which groups offer the best long-range opportunity for salvageability.

With this in mind, the following "target groups" may be considered:

1. *The newly arrived, homeless mentally ill.* Our work in the Project has shown that the longer a chronically mentally ill person remains homeless, the more difficult he is to reach and the more resistant he becomes to mental health treatment. At times, the newly arrived mentally ill homeless are still taking antipsychotic medication or have just recently discontinued the medication. They are more in touch with reality, and treatment rapport is more easily established with them. Some still have some fragment of a relationship with their family or previous mental health treatment program. It is important to capitalize on these remnants of family relationships. At times, contact with the family can be re-established, and with guidance and support, it may be possible to return these persons to their home communities and their families. The Skid Row Project has an excellent working relationship with various agencies who provide free transportation back home.

   The newly arrived are also less likely to have been subjected to the alcohol, street drugs, or the violence so prevalent in Skid Row. These facts severely aggravate underlying mental illness and make help much more difficult to provide.
2. *Battered and at-risk children and runaway youths.* Children and runaway youths are generally much more amenable to treatment and are more salvageable. There are excellent examples of what can be done with innovative and nontraditional treatment approaches to at-risk and battered homeless children,

much as the "Para Los Ninos" Program in Skid Row. The Project has several mental health workers assisting this excellent private agency.

3. *Homeless women.* There is a significantly high incidence of mental illness among the homeless women of Skid Row (we found approximately 80 percent). They lack the basic self-defense skills necessary for survival of most homeless men and are frequently victims of violence. They are very vulnerable and should be targeted early for outreach and assistance.
4. *Homeless elderly.* This group is most vulnerable and defenseless, and should receive high priority for assistance.

Phased Intervention Approach

In general, traditional mental health treatment approaches do not work for the homeless mentally ill; that is why they are homeless. In planning mental health treatment programs for this population, one must be creative, innovative, and compassionate and assume an advocacy role. Outreach is an essential ingredient to any program that assists this group.

It is helpful to think of mental health treatment or intervention for the homeless mentally ill in three basic phases when considering the development of programs.

Phase 1, the emergency first-aid phase. This phase is somewhat equivalent to a "batallion aid station" in a battle zone. In this phase of intervention, emergency assistance is given under acute circumstances. Programmatic goals are early identification and outreach, emergency mental health consultation, training for shelter and other agency personnel, and the "patching" of a mental health program onto existing shelter and agency programs. Development of mental health "drop-in centers" in large catchment areas of the homeless can provide a temporary "safe haven" and a focal point from which first phase intervention goals and objectives can be accomplished.

Phase 2, the stabilization phase. During the stabilization phase, the homeless mentally ill receive an opportunity to

spend anywhere from five to seven days in a "stabilization center." This center should be set up in cooperation with a private shelter or agency that is known and accepted by the homeless mentally ill. At the center they would be given an opportunity to clean up, rest up, and get physical health care as well as intensive mental health care. They would also be provided with linkages to other services, such as social services, vocational rehabilitation, counseling, and so forth. It is anticipated that as many as one-third of the homeless mentally ill could be stabilized in this center to return back to their families, communities, and other appropriate mental health care facilities and programs.

Phase 3, the long-range solutions phase. Long-range solutions to the problems of the homeless mentally ill must be found if any of the programmatic planning is to have lasting benefits. It is of very little value to give shelter and intensive emergency mental health treatment to a person unless this is followed up by some long-range solution to the problem. The "stabilization phase" should automatically be followed by long-range programs for those who require continued long-range mental health care. The Social Security Disability Program, vocational rehabilitation, Veterans' Administration benefits, board-and-care facilities, and so forth, should all be a part of the long-range treatment program. Placement in a therapeutic living center may be necessary for those who are unable to cope with life on their own or do not have a family or supportive structure to return to.

SUMMARY

The plight of the homeless mentally ill has received considerable media attention in recent years, but little of any substantive nature has been done to alleviate their suffering. They are seen in ever increasing numbers in communities across the nation, and their very presence is a testimony to the failure of our society and its mental health treatment system. They have become a grave problem of national proportions and implications. "The streets have

become the asylums of the 1980s" (9) for many of the chronically mentally ill in America.

The homeless problem has become a political battleground in the last few years, and Los Angeles has received the dubious honor of being dubbed the "Homeless Capital of America." We have found in our work among the homeless in the Skid Row area of Los Angeles that between 30 to 50 percent suffer from some serious or incapacitating mental illness. Los Angeles has become a repository for many of the nation's homeless mentally ill in part because of its climate and its liberal social atmosphere and because other communities have used "Greyhound Therapy" (a one-way bus ticket out of town) to get rid of their chronically mentally ill.

The homeless mentally ill are generally without family ties, are defenseless, and are frequently victimized. They are beaten, robbed, and raped daily. They fall prey to many physical diseases because of their exposure to the elements, malnutrition, poor hygiene, and their inability to get basic medical care. They often eat garbage and sleep in alleys and under bushes. They are incapable of utilizing our traditional social, medical, and mental health care systems. In many ways, these systems were never designed to be accessible to the gravely mentally disabled, and fail one of the very populations that they should be serving.

The homeless mentally ill population is the product of many factors. The deinstitutionalization movement of the last 20 years discharged hundreds of thousands of state mental hospital patients into the community with little planning and support. New liberalized mental health laws made involuntary psychiatric treatment almost impossible. It was thought that the new psychiatric "wonder drugs," which were to be the panacea of the mentally ill, combined with the development of local community mental health centers would prevent the necessity of long-term psychiatric hospitalization. Unfortunately, the dollars never followed the patients, and only a fraction of the local community mental health centers were ever built. A system of community care and social support for the mentally ill was never developed.

Society, in general, has seemed unwilling to accept the chronically mentally ill back in the community. The result has been

that many of the chronically mentally ill have not been able to cope with life on their own and have eventually become homeless, ending up on the streets of the skid rows of America. Some communities have attempted to deal with their chronically mentally ill by ignoring them or offering "Greyhound Therapy." The Los Angeles Skid Row area has become a dumping ground for thousands of these helpless, hopeless, chronically mentally ill persons. In a nation as rich and progressive as America, it is inconceivable that this type of problem is allowed to exist today.

The Los Angeles County Department of Mental Health Skid Row Project was developed to help this homeless chronically mentally ill population. The Skid Row Project has developed some unique and innovative treatment mechanisms and methods for reaching out to and helping this special population. Traditional mental health approaches have proven of little value to this population; it is essential to deliver the type of mental health care they can accept in a location where they will accept it. A "storefront approach" and a "patching" of mental health programs upon existing and accepted homeless shelter programs has proven very successful where traditional approaches have failed.

When we began viewing food, shelter, warm clothing, medical care, and a safe, caring environment as part of a mental health treatment program, we were finally able to provide meaningful help to this population. Programmatic planning approaches for the homeless mentally ill should include intervention phases and targeted population groups. Outreach, early identification, and an advocacy approach are also essential. We found that commonsense treatment approaches, such as "rap sessions" in the shelters, "SSI Clinics," and "RTD Clinics" were readily accepted. It must be remembered that the homeless mentally ill problem is a multifaceted one that requires multifaceted approaches. A team approach between the public and private sectors is essential. The Skid Row Project provided a leadership role in assisting public and private agencies to more appropriately address the needs of the homeless in Skid Row through the development of a community coalition named CAMLA.

In 1982, the Skid Row Project was given the National Associa-

tion of Counties (NACO) Achievement Award as one of the most innovative mental health programs in the nation. The project has served an important role in helping to alert Los Angeles County and other communities across the nation as to the seriousness and magnitude of the problems of the homeless mentally ill.

This project demonstrates that community mental health can assume creative, innovative, and nontraditional roles. Caring, reaching out, and a team approach are essential if one is to meet the special needs of the homeless mentally ill. It is hoped that the Skid Row Project can serve as a working model for other communities that are attempting to help this destitute and suffering population.

REFERENCES

1. Baxter E, Hopper K: Private Lives, Public Spaces: Homeless Adults on the Streets of New York City. New York, Community Service Society of New York, 1981

2. Appleby F, Desai P: Documenting the relationship between homeless and psychiatric hospitalization. Hosp Community Psychiatry 36:732–745, July 1985

3. Farr R: The Los Angeles skid row mental health project. The Journal of Psychosocial Rehabilitation 8:64–76, 1984

4. Arce A, Tadlock M, Vergare MJ, et al: A psychiatric profile of street people admitted to an emergency shelter. Hosp Community Psychiatry 34:812–817, 1983

5. Lipton F, Sabatini A, Katz S: Down and out in the city: the homeless mentally ill. Hosp Community Psychiatry 34:817–21, 1983

6. National Institute of Alcohol, Mental Health, and Drug Abuse: The ADAMHA Round Table on the Homeless: a report on the round table on homelessness in America held by the National Institute of Alcohol, Mental Health, and Drug Abuse. Rockville, MD, 1983

7. Farr R: Street People: Is This The Plight of Our Chronically Mentally Ill? Overholser Memorial Day Presentation Paper. Washington DC, St. Elizabeths Hospital, April 1984

8. Farr R: A programmatic view of the homeless mentally ill in Los Angeles. International Journal of Family Psychiatry (in press)

9. Farr R: Testimony from hearings before the U.S. House of Representatives, District of Columbia Subcommittee. Congressional Quarterly, March 19, 1985

85

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91

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A Programmatic View of the Homeless Mentally Ill in Los Angeles County

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I. Introduction

In recent years, there have been many stories and articles written about the increasing number of homeless and disadvantaged people who inhabit the jungles of the decaying sections of most of the cities in America. While the problem has been much publicized, little has been done to try to understand the nature of homelessness, or to devise ways to help this segment of our disenfranchised population. Our work in the Skid Row Project has shown that approximately 50 percent of the homeless there suffer from some serious incapacitating mental illness.

Little information is available as to where these people come from, what types of problems they have experienced, or what factors lead to their homelessness, or what eventually happens to them. They are truly the forgotten people. For a nation with such vast resources, it is incredible that this problem could exist in America today. The existence of this seldom seen population is not a phenomenon limited to larger city skid row

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areas like Los Angeles, but a nationwide phenomenon and a problem of grave national importance. Los Angeles County has recently received the dubious honor of being named the "Homeless Capital of the United States." This is the result of a study released in the Spring of 1984 by the U.S. Department of Housing and Urban Development (HUD), which estimates that there are between 30 and 35 thousand homeless people in Los Angeles County.

II. Statement of Problem

Until recently, most people thought homeless men and women were either chronic alcoholics, derelicts, or dropouts from society who simply did not desire to better themselves. They were, in essence, seen by our society as people who deviated so far from the American work ethic as to be hardly worth consideration. Our work among the homeless in the skid row area of Los Angeles has shown, however, that a large number (approximately 50 percent) suffer from some serious incapacitating mental illness.

The problem of the homeless mentally ill in Los Angeles is a county-wide problem. While most of the attention in Los Angeles has been focused upon the skid row area in downtown Los Angeles, we tend to forget that approximately two-thirds of the 30 to 35 thousand homeless in Los Angeles reside outside the skid row area. While the skid row area constitutes the largest single concentration of the homeless in Los Angeles County (average of ten thousand people), we have found that there are at least 11 other concentrated groupings of homeless people within the county. There is also a diffuse infiltration of single, homeless individuals throughout the entire county. These homeless individuals tend to seek out isolated neighborhoods and small shopping centers where there is less chance of being harmed, and the pickings of the food in the garbage cans of the shopping centers are better.

The homeless mentally ill are a product of many factors, among which are the following:

1. *The drinstitutionalization of the chronically mentally ill.* Hundreds of thousands of chronically mentally ill people were released from state mental hospitals across the United States as part of the deinstitutionalization movement over the past 20 years. There were almost 600,000 state mental hospital beds in the United States twenty years ago, whereas today there are only around 125,000. The dollars gained from closure of the state mental hospitals did not "follow the patients," and only a few of the community mental health centers, which were to have been built to help enable the chronically mentally ill to stay in their communities, were ever completed.

2. *Changing mental health laws* have drastically affected the ability of the mental health treatment system to deliver mental health services to individuals who are chronically mentally ill.

3. The *"miracle" psychiatric drugs* of the 1950s and 1960s did not prove to be the panacea for the chronically mentally ill that it was thought to have been. Many of the patients discharged from mental hospitals refused to continue to take the psychiatric medication given at the time of discharge and as a result their mental condition rapidly deteriorated. Even with medication many patients were simply not able to cope with life on their own in the community.

4. There has been a "failure" of the private and public mental health treatment systems to address properly the long range needs of the chronically mentally ill. This has been, in part, due to lack of resources, but it has also been due to a *lack of "continuity of care"* for chronically mentally ill as well as a *lack of long-range planning and case management.* The disease of schizophrenia, which is the most common cause of chronic mental illness, is frequently a life-long illness that requires lifetime planning in terms of support, rehabilitation, and mental health treatment both for the patient and the family. Mentally ill individuals have numerous brief periods of psychiatric hospitalization, only to be discharged from the hospitals with a prescription and a referral to a community mental health center, and little in the way of case management or continuity of

care has been done to plan or coordinate their support within the community.

5. The social *support systems* or "safety nets" that our society developed to help the disabled and disadvantaged *are inaccessible* to the homeless chronically mentally ill. For example, the application process for the Federal Social Security Disability Program is so difficult and complicated that it is hard for even a mentally well individual to navigate through the miles of bureaucratic red tape. It requires dozens of appointments, months of waiting, and inordinate patience on the part of the SSI employees. It is virtually impossible for chronically mentally ill individuals to gain access to this system on their own.

6. There has been a general *lack of support, training, and involvement for the families of the chronically mentally ill.* As a result, the families have been in many cases, simply "burned out" and are unable to withstand the pressures and turmoil of continually caring for a mentally ill family member and end up alienated from that person. In turn the ill family member leaves or is forced out and ends up on the streets.

7. Mental health treatment for an increasingly large number of young adults has simply been an occasional, short period of acute psychiatric hospitalization during an acute exacerbation of their mental illness. The result has been a "revolving door syndrome" in which the chronically mentally ill are treated only during acute crises and only for short periods of time, without any type of long-range stabilization, treatment, or planning.

8. Many of the chronically mentally ill have become antagonistic and fearful of the "establishment," and as a result *resistant to traditional mental health treatment approaches.* There has also been a lack of flexibility in the Mental Health treatment system to reach and help this group.

9. Many communities across this country have refused to accept their responsibility for the chronically mentally ill within their community. The result has been a "ping-ponging" of the chronically mentally ill from community to community and the

use of a phenomenon known as "Greyhound Therapy," in which communities are ridding themselves of the chronically mentally ill by offering them a one-way bus ticket out of town.

10. Los Angeles has become the "homeless capital" of the United States because of its traditional attractions and mild year-round climate. We have become a major reservoir and *dumping ground* for what is a national problem.

The problems of the homeless chronically mentally ill are multifaceted and interwoven. One cannot address their mental health needs without also addressing their physical needs, including stabilizing their physical environment. They simultaneously require assistance with shelter, food, a safe physical environment, medical care, linkages to appropriate social service agencies, and vocational rehabilitation as well as mental health treatment. Homeless women and children are particularly vulnerable. They are fragile, defenseless, and easily victimized. They are beaten, robbed, and raped daily. They are easy prey for violence, disease, and prostitution. They usually have no safe place to go to.

The homeless mentally ill are frequently exposed to alcohol and drugs once they become homeless, and this usually aggravates their underlying chronic mental illness and makes treatment even more difficult.

The homeless frequently have many physical illnesses. There are no readily accessible health services available to them and because of a lack of health care and the unsanitary conditions in which they live, they develop severe and sometimes fatal physical illnesses. They also serve as a reservoir for communicable diseases within the communities and a possible "powder keg" from a public health point of view.

The homeless chronically mentally ill have few, if any, family ties or friends. Their behavior, which is frequently bizarre at times, is accepted in skid row, and this acceptance and freedom keep them there. Most of the homeless mentally ill are from normal, average families. During periods of acute psychiatric illness and decompensation, they leave home and wan-

der the streets, frequently ending up in the skid row area. Their mental illness is aggravated by the experiences they encounter on the streets; they become increasingly alienated from their families, mental health treatment, and society in general. The presence of the homeless chronically mentally ill in Los Angeles is a growing testimony to the failure of our government, our society, and the public and private mental health treatment systems of this country to address the needs of the chronically mentally ill. The problem is massive and life-threatening. These people are suffering, bleeding, and dying daily in our streets and we must as a society act now.

III. Planning and Program Description

The problems of the homeless mentally ill are multifaceted and interconnected, so that approaches and program development must also be multifaceted and coordinated. It is impossible to deliver mental health treatment to an individual who is homeless, hungry, and suffering from exposure and disease. The first order of mental health treatment must be to stabilize their physical environment and to offer an accessible, "safe place" for them and the type of help they will accept.

The homeless mentally ill in Los Angeles are a very mobile group, and tend to wander from one area of Los Angeles to another, and from outlying areas into skid row and again back to outlying areas. Any systematic effective approach to help this population must be on a countywide basis in order to have any significant or lasting effect upon this population as a whole. Long-range planning and solutions must be included in any programmatic planning. The general thrust for mental health treatment, both public and private, has been a type of "band-aid" therapy to the chronically mentally ill. The dollars and other resources spent over the lifetime of these individuals to "put out fires" is wasted, and really does little to bring about any stability or long-range help for the chronically mentally ill.

In assessing the local problems and the potential for the

homeless mentally ill in Los Angeles County, we must recognize that both the resources for, and the composition of, the homeless population appear to be different in the outlying areas of Los Angeles County from that seen in the inner city skid row area. There are approximately 1800 free beds available in the skid row area for the homeless. This is in part due to large, private shelters and low-cost housing in the form of run-down skid row hotel beds. There are also many other different resources available to the homeless in the skid row area, such as free meals, private and public social service agencies, legal advocacy services for the homeless, health services, social services, mental health services, veterans services, etc. Unfortunately, along with the large number of resources for the homeless in the skid row area, there is also an enormous problem with violence, crime, filth, overcrowding, and disease. The availability of free beds and meals in the skid row area serves as a "magnet" for the homeless throughout the entire county, and many private and public social services agencies send the homeless to the skid row area because of the lack of beds, meals, and resources in their areas.

From a programmatic point of view, two basic approaches should be considered in addressing the needs of the homeless chronically mentally ill.

A. The first programmatic point of view is to *target subgroups* from within the homeless mentally ill population. The reason for this is the size of the homeless population in Los Angeles, which is too large for us to consider at this time as an entire treatment target from both fiscal and clinical perspectives.
B. The second programmatic perspective is to view the mental health planning for the homeless mentally ill in three basic phases.

A. THE "TARGET GROUPS" APPROACH

Considering the large numbers of homeless mentally ill and the present limitations of the Public Mental Health Treat-

ment System, consideration must be given to selecting target groups to help from within this general population of the homeless mentally ill. Selection should be made with several principals in mind: which individuals are more acutely or gravely at risk, which are more amenable to being helped, and which offer the best opportunity for responding to treatment and thus more salvageable. It is very difficult to think along these lines because all of these suffering human beings deserve the opportunity of receiving help, but with current resources so limited and the needs so large, if one does not single out target groups to help from within the homeless, one will soon be overwhelmed and no one will receive any lasting assistance.

With this in mind the following "target groups" should be considered;

1. *The newly arrived, homeless, mentally ill.* Our work in the Skid Row Mental Health Project has shown that the longer a chronically mentally ill person is homeless, the more difficult they are to reach, and the more resistant they are to mental health treatment. In many instances, the newly arrived, homeless mentally ill person's mental condition has not yet deteriorated to the point where they are gravely disabled or as resistant to mental health treatment, often they are still taking antipsychotic medication, or have just recently discontinued the medication. As such, they are more in touch with reality and rapport is much more easily established with them. Some of the newly arrived still have some fragment of contact with their family, friends, or mental health treatment service in another state. It is important to capitalize on these remnants of family relationships in order to assist in bringing about any long-range help to the individual. At times contact with the family can be reestablished, and with guidance and support, it may be possible to return these individuals to their home communities and their families. The newly arrived are less likely to have been subjected to the alcohol, street drugs, or violence, so prevalent in the skid row of Los Angeles. These factors severely aggravate the underlying mental illness and cause them to be much harder to salvage. Early intervention can help to avoid this problem.

2. *The battered and at-risk children of homeless families and the runaway youths.* This second target population within the general homeless group are much more amenable to outreach and treatment, and thus, more salvageable. Model programs such as the "Para Los Ninos Program" in skid row are glowing examples of what can be done with new and nontraditional treatment approaches to the homeless children of skid row.

3. *The female homeless group.* Homeless women are particularly defenseless and vulnerable. They show a significantly higher incidence of severe mental illness than the homeless male group. Approximately 90 percent show serious mental illness. They lack the basic self-defense skills of homeless men and are frequently victims of marauding gangs of hoodlums and criminals.

B. MENTAL HEALTH PLANNING IN THREE BASIC PHASES

From a second programmatic point of view, it is beneficial to think of mental health treatment or intervention for the homeless mentally ill in three basic phases.

Phase 1, or the *emergency first-aid phase*, would be somewhat equivalent to a "battalion aid station."
Phase 2, or the *stabilization phase*, would be equivalent to a "MASH Hospital Unit."
Phase 3, or the *long-range approaches and solutions phase*, would be equivalent to the "evacuation, rehabilitation, and long-term care" in which the more chronically and seriously injured soldiers were *triaged* from the battle area for a longer term or permanent resolution of their medical problems.

In all three of these phases, the assistance must be of a coordinated, multiphasic nature. In all three of the planning phases there should be a coordinated effort, not only by mental health professionals, but by groups experienced in helping the homeless such as the private shelter agencies, public social service agencies, volunteers, police, vocational rehabilitation, self-

help groups, families of the mentally ill, health services, Veteran Administration, alcohol and drug rehabilitation, Social Security Administration, legal advocacy services, and Homeless Community Coalitions.

1. First Phase: Emergency First-Aid Phase ("Battalion Aid Station")

In the first phase, emergency help is given under acute circumstances to a homeless, mentally ill individual. Programmatic goals of this first phase should be outreach and identification, an attempt to offer emergency evaluation and referral to existing mental health services, and other social services programs. By definition, this "referral," should be in the traditional social work concept. That is, a referral is complete only when the actual referring contact is complete. Assistance should be the goal, not referral. An advocacy stance must be maintained in all of the three phases if one is to be successful in trying to reach and help these individuals. They are frequently very leery of any assistance and are in general unreliable to keep their own appointments. It may be necessary, in addition to making arrangements, to actually transport these people to the facility.

Some of the subgoals and recommendations of this emergency first-aid phase are as follows:

(a) *Outreach* is essential if one is to help many of the most severely mentally ill in the homeless population. Mental health and social services personnel should have outreach personnel available to most of the major shelters and gathering places for the homeless (bus stations, soup lines, parks, etc.).

(b) *Professional mental health training and backup* should be available to the police, social services personnel, mission and shelter personnel, Health Services personnel, and other groups of people serving the homeless mentally ill who need guidance and training in handling mentally ill clients.

(c) A mental health program is most effective with this population if it is "piggy-backed," or "patched" onto existing private, community shelter programs. Personnel in the shelter

programs are trusted by the homeless population and this trust can be transferred onto the mental health personnel.

(d) It is important to *disengage from traditional mental health treatment concepts* and to develop the type of mental health treatment that this population will accept. This care should be delivered in the areas and facilities where the homeless feel secure and receptive.

(e) It is imperative to have a *friendly, cooperative attitude* and *approach* on the part of the agency's personnel.

(f) It is necessary to have a *coordinated approach* among all helping groups. No one agency or discipline can do it alone. It is only through a multifaceted and coordinated effort that we can hope to help the homeless mentally ill population.

(g) "Emergency drop-in centers" must be developed for the homeless mentally ill. There is an immediate and urgent need for emergency multipurpose drop-in centers to assist the homeless mentally ill in the major gathering areas of the homeless within Los Angeles County. These emergency drop-in centers must be open 24 hours a day, 7 days a week, to assist the homeless mentally ill. The goal of the emergency drop-in center would be to offer an immediate, safe haven for the homeless mentally ill person. The center in and of itself would offer rest, safety, a shower, snack, toilet facilities, and referrals to appropriate shelter for social, health, and mental health services. The primary responsibility for day-to-day operation and staffing for the emergency drop-in centers should be by one of the private, nonprofit organizations that are already recognized as serving the homeless. They are seen as being caring, safe, organizations by the homeless. The center would work in cooperation and partnership with Mental Health Services as well as various other agencies and care providers necessary to help the homeless mentally ill. These include representatives from health services, social services, the homeless coalition, concerned agencies of Metropolitan Los Angeles (CAMLA), and other similar groups. The emergency evaluation and referral would be a multifaceted type of referral, including not only referral to mental health

treatment, but also shelter, food, health services, alcohol drug rehabilitation, and private volunteer and self-help organizations, social services, Veterans administration, Social Security Administration, vocational rehabilitation, legal advocacy services, and all other support services that are necessary to stabilize and rehabilitate these individuals. Although the emergency drop-in center would be housed in and run by the private shelter organization, it would be imperative that professional mental health personnel be there or available on a 24-hour-a-day 7-day-a-week basis to assist in the mental health evaluation, referral and triage.

(h) It is important to target subgroups within the homeless mentally ill population and to maximize helping the most helpable of these groups. As mentioned previously, the three primary target groups should be the children, the newly arrived homeless, and the homeless women.

(i) Volunteers could be available to assist any of the homeless mentally ill, particularly the newly arrived, to communicate directly with their families and home communities in other states, as well as to offer one-to-one conversation and support.

2. Second Phase: The Stabilization Phase

The second phase entails assisting the homeless mentally ill to establish stabilization of the mental illness, as well as the physical condition and environment. Programs developed for the stabilization phase should encourage the development of concepts that serve the specific, multifaceted needs of this unique problem.

During this stabilization phase, the homeless mentally ill individual would spend anywhere from 5 to 7 days in a *stabilization center*, which would be located in the skid row area, Van Nuys, Santa Monica-Venice, Long Beach, Hollywood, and any other major areas that have large pockets of homeless mentally ill individuals. The stabilization center would be a program in which the homeless mentally ill individual would have an opportunity to clean up, rest, and receive intensive mental health

treatment, physical care, and linkages to appropriate social and other services. Some of the goals and objectives of this stabilization phase are as follows:

(a) The Department of Mental Health would provide the professional mental health manpower necessary to provide intensive mental health treatment. The target group for the short-term stabilization center would be the same three target groups mentioned earlier and those cases that would be most likely to be stabilized within the 5- to 7-day period.

(b) At the same time that the intensive mental health treatment is taking place, the individual would be evaluated and treated for any physical problems by Health Services personnel.

(c) They would also be assisted by the Department of Social Services in applying for the entitlement programs that would provide longer range environmental stabilization to the individual such as SSI disability income.

(d) Also housed within the Center program would be the Department of Public Social Services personnel and Health Services personnel.

(e) It is anticipated that approximately one-third of the individuals going through this program would be immediately salvageable and would be able to be triaged back home or to their board and care facility or some intermediate care facility where their rehabilitation would continue. Those individuals who require more intensive or longer periods of mental health or physical care would be *triaged* to appropriate longer-range programs.

(f) The operation of the stabilization center would be a joint effort between the public sector and private sector of the community. There would be considerable opportunities for volunteer agencies and churches to provide food, clothing, and support within the framework of the stabilization center.

(g) The self-help movement and the organizations associated with self-help movements for the chronically mentally ill should be involved in this stabilization center, as well as in the other two phases of programmatic planning for these individ-

uals. This philosophy of self-help and support through the sharing and the camaraderie of individuals who have gone through the same type of problem has long been an important aspect in stabilizing individuals who suffer from chronic illnesses. A second attribute of the self-help organizations is that they would offer a "safety net" to any of the homeless mentally ill individuals who have in the past been members of these organizations and who may become homeless when they go through an acute phase of their mental illness.

(h) Families of the mentally ill have been increasingly involved in the treatment and planning for their mentally ill family member, and their support groups could be intimately involved in the stabilization center as well. Increasing numbers of families are reporting that their mentally ill family member spends a part of each year homeless on the streets. The communication network that could exist between the emergency drop-in center, the stabilization center, the family, and the self-help organizations would offer an immediate hook-up of the homeless mentally ill individual back to their family, their board and care facility, and to their mental health treatment system.

(i) Conjoint involvement of drug and alcohol rehabilitation counselors for those mentally ill individuals who also have developed drug and alcohol problems would be available at the center; AA and other self-help alcohol and drug groups could also participate.

(j) Vocational rehabilitation and job placement linkages to those individuals who have recovered sufficiently to proceed with that phase of their rehabilitation period would be available at the center.

(k) Coordination of linkage and placement to follow-up outpatient mental health treatment would be provided.

(l) The mental health treatment system must adapt itself to address properly the needs of these individuals once they are returned to the "system" or the whole process will repeat itself. (This is a crucial point.)

(m) The stabilization center would offer a "therapeutic

wedge" to stop further mental and physical disability and deterioration.

(n) Only by pooling the resources and talents of both private and public sectors in a coordinated effort can we hope to help this disenfranchised suffering segment of our population.

3. Third Phase: Long-Range Solution and Approaches Phase

The third and final phase of the three-phase progammatic approach is to provide long-range solutions to the problems of the homeless chronically mentally ill. It is of very little value to give emergency shelter and intensive emergency mental health treatment for a homeless mentally ill individual unless this is followed up by some long-range solution. The stabilization phase of this program should automatically be plugged into such longer range programs, for those who need it, such as the Social Security Disability Program, vocational rehabilitation, Veterans Administration benefits, etc. Placement in a longer range, therapeutic living center may be necessary for those individuals who are unable to cope with life on their own and do not have a family or supportive structure to return to.

Any long-range, programmatic planning for the homeless mentally ill must include some form of long-range housing and environment stabilization as well as mental health care. One well-defined long-range program that can be implemented now is that of the Federal Social Security Disability Program. At the present time it appears to be one of the few viable public support vehicles available to help the chronically mentally disabled individuals who do not have enough family or community support to make it on their own. Assisting the chronically mentally ill individual into accessing the Social Security Disability System requires time, support to the individual, and the assumption of an advocacy role on the part of those individuals trying to help the disabled person. The bureaucratic maze through which one must navigate in order to be enrolled successfully in the Social Security Disability System is one that requires diligence, perseverance, and a lot of support in such practical things as

arrangements for transportation and assurance that the individuals keep their appointments and fill out the various government forms properly. There are a number of significant benefits from the SSI program in addition to the financial assistance that enables the individual to have the basic necessities of life. These benefits include Medi-Cal health insurance, which accompanies the Social Security Disability. This enables partial insurance payments for the mental health services needed by the individual over a period of time. Another strong point for the SSI program is that a significant number of chronically mentally ill individuals in the County are receiving general relief assistance from the County. It amounts to many millions of dollars a year. This general assistance is paid through 100 percent direct County dollars. For every mentally disabled individual who is converted from County general assistance to Federal Social Security disability, there is a direct savings to the County of 100 percent of those county dollars. It is estimated that for every 400 individuals who can be converted from public assistance to the Social Security Disability program, the County of Los Angeles will have a direct tax savings of 1.5 million dollars per year.

There are other significant resources that are available on a State and Federal level, such as grants from HUD and the availability of federal building and equipment to assist in planning for the longer range housing needs for the homeless chronically mentally ill. These funds are usually available for housing only, but one must think of housing as a mental health treatment in order to address properly the needs of the homeless mentally ill. It is important to emphasize that in considering the third or long-range solutions to the chronically mentally ill problems, we must embrace all the elements of a good community support program that is so desperately needed for all the chronically mentally ill within the County. The County Department of Mental Health together with many other important private and public groups serving the chronically mentally ill are currently engaged in developing a networking system for see a return to the large State Hospital and the warehousing

a county-wide community support system program. This "Core Team" for developing the CSS program is currently developing five "Regional Core Teams" to address more appropriately the unique community support needs of the different areas of the County for the chronically mentally ill.

It should be remembered that the homeless mentally ill problem is a county-wide problem and that resources and programs must be developed in each of the regions of the county that have significant homeless populations. We must stop sending the homeless to the skid row area through such things as giving DPSS voucher beds in the skid row area to the homeless mentally ill in such places as Van Nuys or Pasadena. The San Fernando Valley area and especially the Van Nuys area have become significant catchment areas for the homeless mentally ill. Programmatic planning should include the development of an emergency drop-in center or a stabilization center in the Van Nuys area. There is a readily accessible facility on Supulveda Boulevard in Van Nuys that is leased by the Department of Mental Health and houses some of the emergency mental health treatment programs for that region. A portion of this facility is available and could be jointly operated as an emergency drop-in center or a stabilization center. There is an active coalition for the homeless in the San Fernando Valley and recently 10 honorary mayors in the San Fernando Valley area have formed a coalition for the homeless. Church groups in the San Fernando Valley have expressed a strong interest in being involved in a homeless project. This ready-made facility and the emerging coalition offers a unique opportunity and a ready resource for the development of a center for the homeless. Conditions are opportune in the San Fernando Valley at this time to develop a homeless mentally ill project. The mental health treatment systems, both public and private, must address themselves to the problems of the homeless mentally ill problems and be more responsive to their needs. New and innovative mental health treatment approaches and techniques must be developed and built into the existing mental health treatment

systems if we are to address genuinely the unique needs of the homeless mentally ill.

Any long-range planning should also involve vocational rehabilitation and job placement. Sigmund Freud once said that work is second only to love in importance in the stability of the human mind. Most of the homeless mentally ill want to work, and the feeling of self-esteem and confidence that work builds are key factors in the stabilization and rehabilitation of the homeless mentally ill.

Conclusion

In summary then, we see that a new and malignant mental health problem is affecting many of our communities across this nation. It is the plight of the homeless chronically mentally ill "street people." They are growing in alarming numbers and are fast becoming a problem of national proportion and implication. The Los Angeles skid row area has become a repository of the nation's homeless chronically mentally ill.

This new mentally ill population is the product of many factors. They are homeless without normal family ties, defenseless, and easily victimized. They are beaten, robbed, and raped daily. They are incapable of utilizing the existing traditional community support network and are resistant to traditional mental health treatment and approaches. They are in part the product of the deinstitutionalization movement of the last 15 years when hundreds of thousands of State Mental Health Hospital patients across the country were released due to the closing of State Mental Hospitals and the new laws making involuntary psychiatric hospitalization extremely difficult. It was felt that the new "psychiatric wonder drugs" were the panacea of the CMI. It was thought that these psychiatric drugs combined with the proposed development of large numbers of local community mental health centers would prevent the necessity of long-term psychiatric hospitalization. Unfortunately, the "dollars never followed the mentally ill patients," and only

a fraction of the local community mental health centers were ever built. In recent years, even some of those previously built have been closed due to decreased public funding of public mental health treatment.

Unfortunately, as a result of these and other factors many of the released CMI patients could not adapt to or cope with life on their own in the community. Some communities across the nation have attempted to deal with their homeless CMI through "Greyhound Therapy" by offering their helpless CMI residents one-way bus tickets. Los Angeles County has become a repository for thousands of these helpless, hopeless chronically mentally ill individuals. In a nation as rich and progressive as America it is incredible that this type of problem is allowed to exist today.

The problems of the homeless chronically mentally ill are multifaceted and interwoven. One cannot address their mental health needs without also addressing their physical needs, including stabilizing their physical environment. They simultaneously require assistance with shelter, food, a safe physical environment, medical care, linkages to appropriate social service agencies, and vocational rehabilitation as well as mental health treatment.

This is a massive, nation-wide problem, and Los Angeles has become the repository for this national problem. Long-term solutions require coordination and planning on a national level. In considering planning a program development for the homeless mentally ill, two basic approaches should be considered. One, targeting subgroups from within the general homeless population; and the second, a viewing intervention or assistance in three phases: (1) emergency phase, (2) stabilization phase, and (3) long-range phase.

It is possible that some legislative remedies might be necessary to alter existing mental health laws and to create the type of atmosphere that is necessary to make entitlement programs accessible to the homeless mentally ill. While no one wants to

of the chronically mentally ill, there must be some middle ground where some outpatient mental health treatment of a less restrictive nature would be mandatory for those homeless chronically mentally ill individuals who are so disoriented and alienated from society that they are dying from hunger and exposure on our streets.

Private/public sector cooperation is vital to any meaningful or long-range solution to the problem. New and innovative mental health treatment approaches and techniques must be developed and built into the existing mental health treatment systems if we are to address genuinely the unique needs of the homeless mentally ill. It is inconceivable that a nation that is so advanced that it can put a man on the moon should have tens of thousands of homeless mentally ill individuals suffering, bleeding, and dying in our streets. An emergency exists in our streets. The situation is acute, the need is now, we must act to help this suffering disenfranchised segment of our society.

References

Farr, Rodger K. (1984). The Los Angeles skid row mental health program. *Psych. Rehab. J.*, October: 64-76.

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STATEMENT OF MAXENE JOHNSTON, PRESIDENT, WEINGART CENTER ASSOCIATION

Ms. JOHNSTON. Chairman Hawkins, Chairman Roybal, and Representative Martinez. In recognition of the time and the others need to testify, I will certainly try to cut out some of the fat and get to the meat.

So I will make a brief introductory statement and then turn to my colleague, Janet Larkly.

1985 through a creative and innovative formula of funding and management, the community redevelopment agency city dollars in this case, the Weingart Center Association representing the private sector and the American Red Cross brought together staff and dollars, and I will recognize Councilman Bernardi's leadership in bringing this all about, to fund a 242 bed program that we call the screening and referral highways homeless program.

Our focus was to foster self-sufficiency by a variety of approaches to the various groups that we see. In other words, to try to stop the cycle of what I believe can justifiably be referred to as a helter shelter cycle. We wanted to intervene at the right time with the right services.

After 18 months of experience with this program, I think we found that the rule of thirds applies. A third of the folks that we see are displaced with very little they are back on their feet and off the street if we get to them before they spend time being socialized as homeless individuals particularly in the skid row area, learning those behaviors.

Another third are disabled. They are disabled educationally. They are disabled emotionally, and they are disabled medically. And finally the last third are distraught. We get to them too late, and there really is not much that we can do in this type of program.

It is now my privilege to introduce Janet Larkly, a social worker for the Red Cross and manager of the center screening and referral program. She will provide you with a little more detail and a vivid picture of what the homeless do in this program.

STATEMENT OF JANET LARKLY, PROGRAM MANAGER FOR SCREENING AND REFERRAL SERVICES, WEINGART CENTER ASSOCIATION

Ms. LARKLY. Good afternoon. Thank you.

The Weingart Center is a non-profit organization and operates a 10-story, 600-bed facility in Los Angeles skid row. The screening and referral services program was initiated in September 1985.

It represents one of the first collaborative efforts by social service agencies to provide a wide range of needed services to homeless people in a shelter setting. The Weingart Center requested and received from the Los Angeles chapter of the American Red Cross cooperation and support for this demonstration project which would illustrate that with the provision of case work services, it would be possible to break the homeless cycle.

The premise was that if stabilized housing was provided, individuals would then avail themselves of benefits available through wel-

fare, social security, veterans administration, or training and employment opportunities.

With the stability of a regular income a move out of the skid row area would then be a possibility. The pilot program was funded by the Community Redevelopment Agency of the City of Los Angeles for 132 beds. The demonstration project proved so successful that the Weingart agreed to continue the program.

The Community Redevelopment Agency continued the funding and additional funds were obtained from the California State Emergency Shelter program. The program now has a total of 242 beds and is managed by the American Red Cross with a staff of three.

The Weingart targeted two populations of homeless individuals who needed longer term housing and case work services. One, individuals who had been given a 60-day sanction by the general relief section of the department of public social services and two, newly employed individuals who needed temporary housing in order to accumulate their own funds for permanent housing.

In this 60-day sanction group, there is a small percentage who are highly motivated. They take advantage of the stable long-term housing, the case work services, and the referral to agencies and programs in order to enroll in vocational training or seek full time employment.

These individuals do not reapply for general relief, but become part of the work force and the mainstream of society. In order to assist individuals to accomplish this goal intensive services are needed. Employment readiness workshops with instructions on how to apply for work, completion of application forms, and interviewing skills are needed.

Funds are needed for phone calls to prospective employers, appropriate clothing for interviews and transportation funds to get to and from the interviews, an onsite job developer knowledgeable of the problems peculiar to the homeless is needed.

The newly employed individuals who were admitted to the program and the persons from the 60-day sanctions group who have obtained employment are given an opportunity to stay at the Weingart Center for up to 60 days as long as they continue to show proof of earnings and proof of savings to acquire their own residence.

Even though we provide shelter and one hot meal per day by funds from the federal emergency management agency, it is extremely difficult for these individuals to succeed. Once a homeless person obtains full time employment, many things are needed to maintain that employment and it may be one to three weeks before the first full paycheck is received.

Daily transportation is needed to get to and from the job. Before their first paycheck, these people do not have funds for bus fare, and in Los Angeles, it is not possible to walk to most areas. Personal hygiene and grooming items especially for the women are necessary to look presentable in the work place.

Appropriate clothing or required uniforms also cost money. An alarm clock may seem common place, but to a newly employed person in a shelter, it can be crucial in arriving at work on time.

Since September of 1985, we have admitted 1,150 people into the 60-day component, and 794 newly employed, a total of 1,944 people.

The typical person is black, male, age 34 and has completed the 11th grade. His work skills are limited and his work history sporadic. 35 to 40 days is the average length of stay in the program. Of this total, 351 or 18 percent have achieved their goal of independent housing and another 75 or 4 percent have acquired housing in a hotel on a monthly basis.

These are the successes, but they were not easily attained. The individuals found in skid row shelters whether they be situationally homeless or chronically homeless bring with them a myriad of lifelong learned behaviors and problems. Many of these individuals tend to use poor judgment and are often impulsive when making daily decisions.

They are lacking in social skills and have limited capabilities with their written and oral communication. Many, however, are aware of their limitations and are interested in improving themselves so as not to fall back into the homeless cycle.

This is evidenced by the voluntary participation in our life skills and discussion groups. We also work with individuals with drug and alcohol problems or antisocial behavior. But today for this meeting, we are focusing our attention and efforts on the small select group of homeless individuals who do seek assistance in changing their life situations.

As social workers, it is our responsibility to help people help themselves. It is our contention that once provided with the basic necessities of life, shelter, food and clothing, this group is receptive to learning a better life and coping skills. We feel that in the initial period when employment is first obtained, additional funds are beneficial in giving that extra little boost to get started.

An allowance for clothing, personal grooming items, and a temporary bus pass would alleviate that added stress and frustration that is so difficult for these individuals to cope with. Being able to get to work, learn the job and perform at their best can increase the self confidence, motivation and dignity that we all desire and deserve.

Thank you.

Chairman HAWKINS. The Chair asks the two ladies from the—representing the Weingart Center, in accordance with your experience, how many of these individuals are employable? What percentage would you say roughly speaking?

Ms. LARKLY. I am not too good at percentages, and we have found that at different times we have been operating about 18 months now, and at different times you have more individuals who are more interested in gaining work.

We would say probably a quarter percent who are actually there long enough and we feel that if we had more staff that we would be able to give more individualized attention to each person. We are a very large shelter. We have 242 beds.

I have only mentioned two groups. We actually house another group of individuals who we call high risk homeless. There are only three of us and you are talking about 242 people per day. So if we had more staff to give really one on one individualized atten-

tion to the ones who are deeply and sincerely interested, I think we would find the percentages would soar.

Chairman HAWKINS. You do not have any training facilities, do you?

Ms. LARKLY. No, on our premise we do not have. It is a large ten story building. It is primarily a hotel type structure, and with additional space, we would be interested in having some sort of a training facility where more workshops could be presented.

Chairman HAWKINS. Approximately how many do you consider to be mental problems?

Ms. LARKLY. On our program, about one-fourth of the 242 that we have at any given time do receive SSI or are waiting to receive SSI for mental illness. However, many in the 60-day sanction group and the newly employed are very limited socially, and sometimes they are not even with us long enough to really determine the extent, to what extent they may have a mental illness. But many are quite limited functionally.

Chairman HAWKINS. You heard the suggestion of the establishment of a center. I think Councilman Alatorre made a concrete suggestion. I think it came up with one of the other witnesses. What do you think of such an idea? Do you think that would be a practical idea? Are you attempting to serve as a center yourself?

Ms. LARKLY. Well, I think it would be very difficult to have one particular center. Homeless people do not have transportation. Therefore, if the center is on block X and you are at block A, it is a long ways away. If you wanted to have a clearing center, I think you would have to have several around the entire Los Angeles area.

Homeless people do not even have money for a phone call unless they happen to ask someone to get money. So anyone needing to help homeless has to be extremely readily available.

I would like to make one comment. It has been brought up a couple of times earlier that all of the homeless activities in Los Angeles are really not coordinated, and I really would like to speak to that for just a second.

In Los Angeles, we have what is called the county wide coalition for homeless, and it is where all of the helping agencies, city, county, state and private meet once a month to make each of us aware what the programs are, what the services are, any changes, so that there is coordination among us individuals who work with homeless.

It is true not all services are coordinated with all of the public and private sectors, but we really are a very united group working together.

Chairman HAWKINS. Well, you have coordination but you do not have too many services to coordinate, do you?

Ms. LARKLY. That is true.

Ms. JOHNSTON. I would ask that perhaps this distinguished committee could take a message back to Washington, and that is, let us get the food stamp program implemented. It is amazing. I have already been interviewed for how the food stamp program will be implemented, when no one knows when it will be implemented.

So that would greatly assist us in providing more resources. It is hard to think of people functioning when they are hungry.

Chairman HAWKINS. Mr. Roybal?

Mr. ROYBAL. Thank you, Mr. Chairman. I would like to congratulate the panel for excellent testimony, and I do have some questions particularly with regard to a statement that was made by Dr. Farr and others in which you say there is a lack of available low cost housing.

The homeless population in the city is anywhere between 30,000 to 50,000 in the city alone and surrounding areas. Would low cost housing actually solve the problem if it is not congregate housing where various facilities are put together in one place?

What kind of housing are we talking about?

Dr. FARR. When I was talking about the availability of low cost housing, I think it has two impacts. One is that there are a group of people that that is a root cause, particularly the older people or those that are on some type of disability pension, fixed income with very, very low incomes.

And in the metropolitan areas like in Los Angeles and downtown, housing is expensive, and what we do have is being lost, torn up and redeveloped and that. So that at times somebody who may have lived in the same place for 20 years and barely gotten by can be evicted because of this and they find themselves homeless and in that cycle. So I mentioned that from that point of view. As far as shelter being a destination for the homeless, particularly the mentally ill. I do not think that it is.

In fact, it can be a cruel entrapment for them because sheltering without addressing the root causes. I know when I have been back to New York and I have seen some of the sheltering that goes on there in large armories and things like that. It is no wonder that many of the homeless would rather stay out in the streets in freezing weather.

So that I think we have to be very careful when we talk about housing as solving the problems of the homeless. I do not think it does. I think housing together with addressing the root causes and the impediments that are leading to it then have some meaning.

Mr. ROYBAL. Well, I think that that has to be constantly explained because it is left with the individual that housing in itself would solve most of the problems. But I understand that it will not.

Dr. FARR. It will not.

Mr. ROYBAL. Because if you do not put in the congregate aspect to housing with all these other facilities that would be needed, then housing as housing alone in my opinion would be useless.

Dr. FARR. Absolutely right.

Mr. ROYBAL. All right. Now, what happens then with the instances of tuberculosis? Again, you say that it is 300 times more than the norm. There was a time let us say even ten years ago when we thought we had eradicated tuberculosis. Now, tuberculosis is on the increase, and it has been on the increase well for many years.

But particularly in the last ten years. If this is 300 times the regular norm then the instance of tuberculosis among the homeless has reached a proportion that is most alarming.

Dr. FARR. I would agree.

Mr. ROYBAL. What happens to these people? We know there is some way in which we find out that it is 300 times the norm. Is

this because the reporting agencies brought that to our attention? Is this an estimate?

So what I am asking is how do we know that it is 300 times the norm? And if we do know, why are these people not being taken care of if they do in fact have a positive sputum for an example, and are communicable? Can you answer that, doctor?

Dr. FARR. Well, I think you bring up two very important aspects to the tuberculosis among the homeless. One is the infection rate, and the other is the available resources or the way that we can treat them.

In answer to your first question in terms of the rate. There are four large studies which have just been completed. Three are published, and one is in the process of being published, and I do have copies of those. And if you would like, I would be happy to furnish them to you.

And they find very similar statistics in terms of going out among the homeless and sampling them and then doing either PBD skin tests or chest films and sputem cultures so that you can see. So these estimates are based upon actual precise scientific studies that have been done in the last two years.

Mr. ROYBAL. Are these studies that go beyond the tuberculin test?

Dr. FARR. Oh, yes.

Mr. ROYBAL. They are actually diagnoses that are made?

Dr. FARR. That is right.

Mr. ROYBAL. Again, the question is, why are they insanitary?

Dr. FARR. Well, that is very interesting. When we discuss this in American Lung Association meetings because the other part that you are mentioning concerns me and that is with the homeless who have tuberculosis. The treatment for tuberculosis involves the use of two common drugs for a period of nine months to a year and a half.

And to follow the homeless person, to offer them a warm environment where they can try to get over this, even to go out and give them the medicine for three months let alone six months to a year is almost impossible so that the failure rate in terms of treatment for the homeless with tuberculosis is also astronomical as is the infection rate.

The other thing was in one of the four studies, one was in Boston, almost half of the individuals in the homeless that has tuberculosis were resistant to the two drugs. So we are talking about another catastrophic problem. We are brewing a population that not only is not being treated properly but is now becoming resistant to the two medicines.

And one of the things that I heard not only in the articles but in the lung meetings is they are trying to devise methods in terms of going out and finding these people once a week, giving them their medicine twice a week or something like this for nine months. You can forget that.

If they are in a shelter for five days at a time and they are wandering, I do not think you can devise a method. We do have public health laws which allow for the health authorities to come in, and offer housing for these individuals until their sputem is clear, until their chest is clear, but we are not implementing those laws.

Primarily because of the TB sanitariums have been obliterated and there is no place to put these, or no funds to treat them with.

Chairman HAWKINS. The Chair would like to thank the witnesses. That concludes the panel. We appreciate your cooperation.

The next panel will consist of the individuals whose names I will call. Gabriel Cortina, Assistant Superintendent for Adult and Occupational Education, L.A. Unified School District.

Steven Porter, Assistant General Manager, City of Los Angeles, Community Development Department. Robert Nelson, Acting Executive Director for Los Angeles Business Labor Council. Martha Brown Hicks, President, Skid Row Development Corp. Nancy Mintie, Director of the Inner City Law Center.

[Prepared statement of Janet Larkly follows:]

PREPARED STATEMENT OF JANET LARKLY, PROGRAM MANAGER, SCREENING AND REFERRAL SERVICES, WEINGART CENTER ASSOCIATION

THE WEINGART CENTER ASSOCIATION, A NON PROFIT ORGANIZATION, OPERATES A TEN STORY, 600 BED FACILITY IN LOS ANGELES' SKID ROW. THE SCREENING AND REFERRAL SERVICES PROGRAM WAS INITIATED IN SEPTEMBER, 1985. IT REPRESENTS ONE OF THE FIRST COLLABORATIVE EFFORTS BY SOCIAL SERVICE AGENCIES TO PROVIDE A WIDE RANGE OF NEEDED SERVICES TO HOMELESS PEOPLE IN A SHELTER SETTING.

THE WEINGART CENTER REQUESTED AND RECEIVED FROM THE LOS ANGELES CHAPTER OF THE AMERICAN RED CROSS COOPERATION AND SUPPORT FOR THIS DEMONSTRATION PROJECT WHICH WOULD ILLUSTRATE THAT WITH THE PROVISION OF CASEWORK SERVICES IT WOULD BE POSSIBLE TO BREAK THE HOMELESS CYCLE. THE PREMISE WAS THAT IF STABILIZED HOUSING WAS PROVIDED, INDIVIDUALS WOULD THEN AVAIL THEMSELVES OF BENEFITS AVAILABLE THROUGH WELFARE, SOCIAL SECURITY, VETERANS ADMINISTRATION, OR TRAINING AND EMPLOYMENT OPPORTUNITIES. WITH THE STABILITY OF A REGULAR INCOME A MOVE OUT OF THE SKID ROW AREA WOULD THEN BE A POSSIBILITY. THE PILOT PROGRAM WAS FUNDED BY THE COMMUNITY REDEVELOPMENT AGENCY OF THE CITY OF LOS ANGELES FOR 132 BEDS. THE DEMONSTRATION PROJECT PROVED SO SUCCESSFUL THAT THE WEINGART ENTHUSIASTICALLY AGREED TO CONTINUE THE PROGRAM, THE COMMUNITY REDEVELOPMENT AGENCY

CONTINUED THE FUNDING, AND ADDITIONAL FUNDS WERE OBTAINED FROM THE CALIFORNIA STATE EMERGENCY SHELTER PROGRAM. THE PROGRAM NOW HAS A TOTAL OF 242 BEDS AND IS MANAGED BY THE AMERICAN RED CROSS WITH A STAFF OF THREE.

THE WEINGART TARGETED TWO POPULATIONS OF HOMELESS INDIVIDUALS WHO NEEDED LONGER-TERM HOUSING AND CASEWORK SERVICES:

1. INDIVIDUALS WHO HAVE BEEN GIVEN A 60 DAY SANCTION BY THE GENERAL RELIEF SECTION OF THE DEPARTMENT OF SOCIAL SERVICES,
2. NEWLY EMPLOYED INDIVIDUALS WHO NEEDED TEMPORARY HOUSING IN ORDER TO ACCUMULATE THEIR OWN FUNDS FOR PERMANENT HOUSING.

IN THIS 60 DAY SANCTION GROUP THERE IS A SMALL PERCENTAGE WHO ARE HIGHLY MOTIVATED. THEY TAKE ADVANTAGE OF THE STABLE LONG TERM HOUSING, THE CASEWORK SERVICES AND THE REFERRALS TO AGENCIES AND PROGRAMS IN ORDER TO ENROLL IN VOCATIONAL TRAINING OR SEEK FULL TIME EMPLOYMENT. THESE INDIVIDUALS DO NOT REAPPLY FOR GENERAL RELIEF, BUT BECOME PART OF THE WORK FORCE AND THE MAINSTREAM OF SOCIETY. IN ORDER TO ASSIST INDIVIDUALS TO ACCOMPLISH THIS GOAL, INTENSIVE SERVICES ARE NEEDED. EMPLOYMENT READINESS WORKSHOPS WITH INSTRUCTIONS ON HOW TO APPLY FOR WORK, COMPLETION OF APPLICATION FORMS, AND INTERVIEWING SKILLS ARE NEEDED. FUNDS ARE NEEDED FOR PHONE CALLS TO PROSPECTIVE EMPLOYERS, APPROPRIATE CLOTHING FOR

INTERVIEWS AND TRANSPORTATION FUNDS TO GET TO AND FROM THE INTERVIEWS. AN ON SITE JOB DEVELOPER KNOWLEDGEABLE OF THE PROBLEMS PECULIAR TO THE HOMELESS IS NEEDED.

THE NEWLY EMPLOYED INDIVIDUALS WHO WERE ADMITTED TO THE PROGRAM, AND THE PERSONS FROM THE 60 DAY SANCTION GROUP WHO HAVE OBTAINED EMPLOYMENT, ARE GIVEN AN OPPORTUNITY TO STAY AT THE WEINGART CENTER FOR UP TO 60 DAYS AS LONG AS THEY CONTINUE TO SHOW PROOF OF EARNINGS, AND PROOF OF SAVINGS TO ACQUIRE THEIR OWN RESIDENCE. EVEN THOUGH WE PROVIDE SHELTER AND ONE HOT MEAL PER DAY BY FUNDS FROM THE FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA), IT IS EXTREMELY DIFFICULT FOR THESE INDIVIDUALS TO "SUCCEED." ONCE A HOMELESS PERSON OBTAINS FULL TIME EMPLOYMENT, MANY THINGS ARE NEEDED TO MAINTAIN THAT EMPLOYMENT AND IT MAY BE ONE TO THREE WEEKS BEFORE THE FIRST FULL PAY CHECK IS RECEIVED. DAILY TRANSPORTATION IS NEEDED TO GET TO AND FROM THE JOB. BEFORE THEIR FIRST PAYCHECK THESE PEOPLE DO NOT HAVE FUNDS FOR BUS FARE, AND IN LOS ANGELES IT IS NOT POSSIBLE TO WALK TO MOST AREAS. PERSONAL HYGIENE AND GROOMING ITEMS, ESPECIALLY FOR THE WOMEN, ARE NECESSARY TO LOOK PRESENTABLE IN THE WORKPLACE. APPROPRIATE CLOTHING OR REQUIRED UNIFORMS ALSO COST MONEY. AN ALARM CLOCK MAY SEEM COMMON PLACE, BUT TO A NEWLY EMPLOYED PERSON IN A SHELTER, IT CAN BE CRUCIAL IN ARRIVING AT WORK ON TIME.

SINCE SEPTEMBER OF 1985 WE HAVE ADMITTED 1,150 PEOPLE INTO THE 60 DAY COMPONENT AND 794 NEWLY EMPLOYED; A TOTAL OF 1,944 PEOPLE. THE TYPICAL PERSON IS BLACK, MALE, AGE 34, AND HAS COMPLETED THE 11TH GRADE. HIS WORK SKILLS ARE LIMITED AND HIS WORK HISTORY SPORADIC. 35 - 40 DAYS IS THE AVERAGE LENGTH OF STAY IN THE PROGRAM. OF THIS TOTAL, 351 OR 18% HAVE ACHIEVED THEIR GOAL OF INDEPENDENT HOUSING AND ANOTHER 75 OR 4% HAVE ACQUIRED HOUSING IN A HOTEL ON A MONTHLY BASIS. THESE ARE THE SUCCESSES, BUT THEY WERE NOT EASILY ATTAINED. THE INDIVIDUALS FOUND IN SKID ROW SHELTERS, WHETHER THEY BE "SITUATIONALLY" HOMELESS OR "CHRONICALLY HOMELESS," BRING WITH THEM A MYRIAD OF LIFE-LONG LEARNED BEHAVIORS AND PROBLEMS. MANY OF THESE INDIVIDUALS TEND TO USE POOR JUDGMENT AND ARE OFTEN IMPULSIVE WHEN MAKING DAILY DECISIONS. THEY ARE LACKING IN SOCIAL SKILLS AND HAVE LIMITED CAPABILITIES WITH THEIR WRITTEN AND ORAL COMMUNICATION. MANY, HOWEVER, ARE AWARE OF THEIR LIMITATIONS AND ARE INTERESTED IN IMPROVING THEMSELVES SO AS NOT TO FALL BACK INTO THE HOMELESS CYCLE. THIS IS EVIDENCED BY THE VOLUNTARY PARTICIPATION IN OUR "LIFE-SKILLS" AND DISCUSSION GROUPS.

WE ALSO WORK WITH INDIVIDUALS WITH DRUG AND ALCOHOL PROBLEMS OR ANTI-SOCIAL BEHAVIOR. BUT TODAY WE ARE FOCUSING OUR ATTENTION AND EFFORTS ON THE SMALL SELECT GROUP OF HOMELESS INDIVIDUALS WHO DO SEEK ASSISTANCE IN CHANGING THEIR LIFE

SITUATIONS. AS SOCIAL WORKERS IT IS OUR RESPONSIBILITY "TO HELP PEOPLE HELP THEMSELVES." IT IS OUR CONTENTION THAT ONCE PROVIDED WITH THE BASIC NECESSITIES OF LIFE; SHELTER, FOOD AND CLOTHING, THIS GROUP IS RECEPTIVE TO LEARNING BETTER LIFE AND COPING SKILLS. WE FEEL THAT IN THE INITIAL PERIOD WHEN EMPLOYMENT IS FIRST OBTAINED, ADDITIONAL FUNDS ARE BENEFICIAL IN GIVING THAT EXTRA LITTLE BOOST TO GET STARTED. AN ALLOWANCE FOR CLOTHING, PERSONAL GROOMING ITEMS AND A TEMPORARY BUS PASS WOULD ALLEVIATE THAT ADDED STRESS AND FRUSTRATION THAT IS SO DIFFICULT FOR THESE INDIVIDUALS TO COPE WITH. BEING ABLE TO GET TO WORK, LEARN THE JOB AND PERFORM AT THEIR BEST CAN INCREASE THE SELF CONFIDENCE, MOTIVATION AND DIGNITY THAT WE ALL DESIRE AND DESERVE.

RESPECTFULLY SUBMITTED
JANET LARKLY
PROGRAM MANAGER

Chairman HAWKINS. Let me remind everyone that we are running almost an hour behind now. We are losing time, and we will never get through even with the scheduled witnesses if we do not try to cooperate with each other to allow a long list of witnesses that have been handed to the chair that are supposed to be witnesses this afternoon.

So I would again caution the witnesses to try and confine yourself to not more than five minutes, and obviously if we do not, we will not have time for questions. The first witness is Gabriel Cortina.

Mr. MARTINEZ. Just say hello to an old friend. I just could not remember your title.

Mr. CORTINA. Actually, your memory was outstanding.

STATEMENT OF GABRIEL CORTINA, ASSISTANT SUPERINTENDENT FOR ADULT AND OCCUPATIONAL EDUCATION, LOS ANGELES UNIFIED SCHOOL DISTRICT

Mr. CORTINA. Good afternoon, Honorable Congressman Roybal, Congressman Hawkins, and Congressman Martinez, Councilman Bernardi.

I am Gabriel Cortina, Assistant Superintendent of Los Angeles Unified School District, and the District's representative to the private industry council. Thank you for this opportunity to share with you information regarding the L.A. Unified District's commitment in partnership for education and training of their homeless.

I have the responsibility for education and training services provided for out of school youth and the adults in the area served by our school district. It is the nation's largest adult education and job training program.

Last year 382,000 youth and adults enrolled in the various programs offered by the district. Included 192,000 on ESL consisting primarily of recent immigrants from 79 different countries, 85,000 youth and adults in employment preparation programs, and another 48,000 literacy, GED and diploma prep classes.

These services are offered in over 700 community sites operated as branches from 26 adult schools and 12 employment preparation centers opened 14 hours daily. All of our programs are open-entry, open-exit. That is to say, we can enroll students throughout the year.

And they are competency based which means that students progress as quickly or as slowly as is required for them to be successful. The operating characteristics of these programs reflect careful honing to accommodate the objectives of the federal ABE and manpower training program that have been in existence for almost 25 years.

With respect to our ability to serve additional students or to extend our programs to meet the specialized needs of our Los Angeles population, we are faced with severe funding problems and federal regulations which inhibit our flexibility.

Regarding our funding, we are currently operating over the funding cap authorized by the state legislature after Prop. 13. This cap limits our state funding for literacy, English as a second language,

job training and basic education to an annual growth of two and a half percent.

The population has been growing at a rate exceeding 10 percent. Los Angeles last year became the largest port of entry in the country serving 79 different nationalities, 40 percent of all new immigrants entered the United States through Los Angeles.

As a consequence significant segments of the population urgently need these services. We are bracing for the educational impact of the new amnesty bill and expect that over 500,000 will register for the program in the Los Angeles area alone.

The Los Angeles Catholic Archdiocese has already registered 228,000 individuals and has requested the provision of amnesty prep. classes in ESL citizenship and government. Next year, the GAIN program, California's workfare program, will be implemented in Los Angeles County.

The Department of Public Social Services anticipates that 70,000 youth and adults will be eligible for referral services and that a majority will require substantial literacy and basic ed skills prior to or in conjunction with job training. These slots will not be available unless the cap is lifted or the percent is substantially increased.

We will be unable to cope with the growing need to couple education and training with the needs of these populations or as programs are developed for the homeless. With regard to federal regulations, the JTPA mechanism nationwide and particularly in Los Angeles is a placement oriented program designed to recruit and enroll the most employable of the large multi-segmented disadvantaged populations.

It also operates on a competitive cost per placement mode effectly screening out the riskiest populations. The homeless population is among the least employable and will be among the most costly to serve.

There must be provisions to focus on the realistic needs of the homeless population and to earmark the necessary JPT resources to design and implement an effective design to the homeless who are capable of employment productivity in society.

I believe that this priority must be established by Congress at the national level, and that a portion of the funds available should be earmarked for that purpose. Our district has had an opportunity to be involved with the education and training the homeless.

Several community based organizations included our district in a partnership as they pursued avenues to obtain funding for the primary needs of the homeless, housing, food, clothing, psychological assistance in counseling, warmth and acceptance as an important living being.

The simple availability of education and job training without this foundation will not work. What must our youth wonder about a society which allows its older generation to lie helplessly in the street or on the sidewalk to be stepped over, avoided or ignored?

I believe that unless action is taken to reverse this phenomenon, we are in danger of breeding an acceptance of this condition in society in the minds of our future generations. The homeless population is a disconnected segment of society, isolated from their families, friends, society and sometimes from themselves. Disconnected

from the bureaucracies and services which are designed to serve those most persistent in accessing services, documenting eligibility and who are able to sustain themselves and their dignity during the process.

The problem must be elevated to that of a national and state priority. Federal and state guidelines must reflect this priority and facilitate the utilization of existing funding sources and mechanisms to assist the homeless.

This can be coupled to comprehensive research efforts to study the special problems and solutions. I am going to skip some. Locally, there is a need for joint planning among the public community base and private sectors. Each agency has a responsibility to design a coordinated process which is applicable to the unique needs of the homeless population.

As we know those least able to help themselves are the most difficult to serve. In addition to fostering the cooperation between agencies, there is also a need to seek additional congressional funding. At present, most agencies are heavily strained by the rapid growth of multiple subcultures and immigrants into the Los Angeles area.

Congressional funding would allow public and private sector agencies to provide these basic services to those most in need. Within the education and job training resources available to our district, we are prepared to participate in any agency cooperative effort which will alleviate the plight of the homeless.

Thank you.

Chairman HAWKINS. Thank you. The next witness is Mr. Steven Porter, Assistant General Manager of the City of Los Angeles, Community Development Department.

[Prepared statement of Gabriel Cortina follows:]

PREPARED STATEMENT OF GABRIEL CORTINA, ASSISTANT SUPERINTENDENT, LOS ANGELES UNIFIED SCHOOL DISTRICT

GOOD AFTERNOON.

I AM GABRIEL CORTINA, ASSISTANT SUPERINTENDENT IN THE LOS ANGELES UNIFIED SCHOOL DISTRICT, AND THE DISTRICT'S REPRESENTATIVE TO THE LOS ANGELES PRIVATE INDUSTRY COUNCIL. THANK YOU FOR THIS OPPORTUNITY TO SHARE WITH YOU SOME INFORMATION REGARDING THE LOS ANGELES UNIFIED SCHOOL DISTRICT'S COMMITMENT AND PARTNERSHIP FOR EDUCATION AND TRAINING OF THE HOMELESS. I HAVE THE RESPONSIBILITY FOR EDUCATION AND TRAINING SERVICES PROVIDED FOR OUT OF SCHOOL YOUTH AND ADULTS IN THE AREA SERVED BY OUR SCHOOL DISTRICT. IT IS THE NATION'S LARGEST ADULT EDUCATION AND JOB TRAINING PROGRAM.

LAST YEAR, 382,000 YOUTH AND ADULTS ENROLLED IN THE VARIOUS PROGRAMS OFFERED BY THE SCHOOL DISTRICT. THIS

INCLUDED 192,000 IN E.S.L. CONSISTING PRIMARILY OF RECENT IMMIGRANTS FROM 79 DIFFERENT COUNTRIES; 85,000 YOUTH AND ADULTS IN EMPLOYMENT PREPARATION PROGRAMS, AND ANOTHER 48,000 IN LITERACY, G.E.D. AND DIPLOMA PREPARATION CLASSES.

THESE SERVICES ARE OFFERED IN OVER 700 COMMUNITY SITES, OPERATED AS BRANCHES, FROM 26 ADULT SCHOOLS AND 12 EMPLOYMENT PREPARATION CENTERS, OPEN 14 HOURS DAILY. ALL OF OUR PROGRAMS ARE OPEN ENTRY/OPEN EXIT; THAT IS TO SAY, WE CAN ENROLL STUDENTS THROUGHOUT THE YEAR AND THEY ARE COMPETENCY BASED, WHICH MEANS THAT STUDENTS PROGRESS AS QUICKLY OR AS SLOWLY AS IS REQUIRED FOR THEM TO BE SUCCESSFUL.

THE OPERATING CHARACTERISTICS OF THESE PROGRAMS REFLECT CAREFUL HONING TO ACCOMMODATE THE OBJECTIVES OF THE FEDERAL A.B.E. AND MANPOWER TRAINING PROGRAMS THAT HAVE BEEN IN EXISTENCE FOR ALMOST 25 YEARS.

WITH RESPECT TO OUR ABILITY TO SERVE ADDITIONAL STUDENTS - OR TO EXTEND OUR PROGRAMS TO MEET THE SPECIALIZED NEEDS

OF OUR LOS ANGELES POPULATIONS, WE ARE FACED WITH SEVERE FUNDING PROBLEMS AND FEDERAL REGULATIONS WHICH INHIBIT OUR FLEXIBILITY.

REGARDING OUR FUNDING, WE ARE CURRENTLY OPERATING OVER THE FUNDING "CAP" AUTHORIZED BY THE STATE LEGISLATURE AFTER PROPOSITION 13. THIS CAP LIMITS OUR STATE FUNDING FOR LITERACY, ENGLISH AS A SECOND LANGUAGE, JOB TRAINING AND BASIC EDUCATION TO AN ANNUAL GROWTH OF 2-1/2 PER CENT.

THE POPULATION HAS BEEN GROWING AT A RATE EXCEEDING 10 PER CENT. LAST YEAR, LOS ANGELES BECAME THE LARGEST PORT OF ENTRY IN THE COUNTRY - SERVING 79 DIFFERENT NATIONALITIES. 40 PERCENT OF ALL NEW IMMIGRANTS INTO THE UNITED STATES ENTER THROUGH LOS ANGELES. AS A CONSEQUENCE, SIGNIFICANT SEGMENTS OF THE POPULATION URGENTLY NEED THESE SERVICES.

WE ARE BRACING FOR THE EDUCATIONAL IMPACT OF THE NEW AMNESTY BILL AND EXPECT THAT OVER 500,000 WILL REGISTER FOR THE PROGRAM IN THE LOS ANGELES AREA ALONE. THE

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CATHOLIC ARCHDIOCESE HAS ALREADY REGISTERED 228,200 AND HAS REQUESTED THE PROVISION OF "AMNESTY PREPARATION" CLASSES IN E.S.L., CITIZENSHIP AND GOVERNMENT.

NEXT YEAR, THE GAIN PROGRAM, CALIFORNIA'S WORKFARE PROGRAM, WILL BE IMPLEMENTED IN LOS ANGELES COUNTY. THE DEPARTMENT OF PUBLIC SOCIAL SERVICES ANTICIPATES THAT 70,000 YOUTH AND ADULTS WILL BE ELIGIBLE FOR REFERRAL SERVICES AND THAT A MAJORITY WILL REQUIRE SUBSTANTIAL LITERACY AND BASIC EDUCATION SKILLS PRIOR TO, OR IN CONJUNCTION WITH, JOB TRAINING. THESE SLOTS WILL NOT BE AVAILABLE UNLESS THE CAP IS LIFTED, OR THE PERCENT SUBSTANTIALLY INCREASED. WE WILL BE UNABLE TO COPE WITH THE GROWING NEED TO COUPLE EDUCATION AND TRAINING WITH THE NEEDS OF THESE POPULATIONS, OR AS PROGRAMS ARE DEVELOPED FOR THE HOMELESS.

WITH REGARD TO FEDERAL REGULATIONS:

THE JTPA MECHANISM NATIONWIDE, AND PARTICULARLY IN LOS ANGELES, IS A PLACEMENT ORIENTED PROGRAM, DESIGNED TO RECRUIT AND ENROLL THE MOST EMPLOYABLE OF THE LARGE MULTI-SEGMENTED DISADVANTAGED POPULATIONS.

IT ALSO OPERATES UNDER A COMPETITIVE COST PER PLACEMENT MODE, EFFECTIVELY SCREENING OUT RISKY POPULATIONS. THE "HOMELESS" POPULATION IS AMONG THE LEAST EMPLOYABLE AND WILL BE AMONG THE MOST COSTLY TO SERVE.

THERE MUST BE PROVISIONS TO FOCUS ON THE REALISTIC NEEDS OF THE HOMELESS POPULATION AND TO EARMARK THE NECESSARY JTPA RESOURCES TO DESIGN AND IMPLEMENT AN EFFECTIVE DESIGN TO SERVE FOR THE HOMELESS WHO ARE CAPABLE OF EMPLOYMENT AND PRODUCTIVITY IN SOCIETY.

I BELIEVE THAT THIS PRIORITY MUST BE ESTABLISHED BY CONGRESS AT THE NATIONAL LEVEL AND THAT A PORTION OF THE FUNDS AVAILABLE SHOULD BE EARMARKED FOR THAT PURPOSE.

OUR DISTRICT HAS HAD AN OPPORTUNITY TO BE INVOLVED WITH THE EDUCATION AND TRAINING OF THE HOMELESS. SEVERAL COMMUNITY

BASED ORGANIZATIONS INCLUDED OUR DISTRICT IN A PARTNERSHIP AS THEY PURSUED AVENUES TO OBTAIN FUNDING FOR THE PRIMARY NEEDS OF THE HOMELESS -

-6-

- HOUSING
- FOOD
- CLOTHING
- PSYCHOLOGICAL ASSISTANCE AND COUNSELING
- WARMTH AND ACCEPTANCE AS AN IMPORTANT LIVING BEING

THE SIMPLE AVAILABILITY OF EDUCATION AND JOB TRAINING WITHOUT THIS FOUNDATION WILL NOT WORK.

WHAT MUST OUR YOUTH WONDER ABOUT A SOCIETY WHICH ALLOWS IT'S OLDER GENERATION TO LIE HELPLESLY IN THE STREET, OR ON THE SIDEWALK...TO BE STEPPED OVER, AVOIDED OR IGNORED? I BELIEVE THAT, UNLESS ACTION IS TAKEN TO REVERSE THIS PHENOMENON, WE ARE IN DANGER OF BREEDING AN ACCEPTANCE OF THIS CONDITION IN SOCIETY IN THE MINDS OF OUR FUTURE GENERATIONS.

THE HOMELESS POPULATION IS A DISCONNECTED SEGMENT OF SOCIETY - ISOLATED FROM THEIR FAMILIES, FRIENDS, SOCIETY AND SOMETIMES, FROM THEMSELVES ... DISCONNECTED FROM THE BUREAUCRACIES AND SERVICES WHICH ARE DESIGNED TO SERVE

THOSE MOST PERSISTENT IN ACCESSING SERVICES, DOCUMENTING ELIGIBILITY AND WHO ARE ABLE TO SUSTAIN THEMSELVES AND THEIR DIGNITY DURING THE PROCESS.

THE PROBLEM MUST BE ELEVATED TO THAT OF A NATIONAL AND STATE PRIORITY. FEDERAL AND STATE GUIDELINES MUST REFLECT THIS PRIORITY AND FACILITATE THE UTILIZATION OF EXISTING FUNDING SOURCES AND MECHANISMS TO ASSIST THE HOMELESS.

THIS CAN BE COUPLED TO COMPREHENSIVE RESEARCH EFFORTS TO STUDY THE SPECIAL PROBLEMS AND SOLUTIONS WHICH APPLY TO THE HOMELESS AND TO PROVIDE FOR FLEXIBILITY AND CREATIVITY IN THE USE OF FUNDS CURRENTLY AVAILABLE BY ALL AGENCIES IMPACTED OR RESPONSIBLE FOR THESE SERVICES.

LOCALLY, THERE IS A NEED FOR JOINT PLANNING AMONG THESE PUBLIC, COMMUNITY BASED, AND PRIVATE SECTOR AGENCIES. EACH AGENCY HAS A RESPONSIBILITY TO DESIGN A COORDINATED PROCESS WHICH IS APPLICABLE TO THE UNIQUE NEEDS OF THE HOMELESS POPULATION. AS WE KNOW, THOSE LEAST ABLE TO HELP THEMSELVES ARE THE MOST DIFFICULT TO SERVE.

-8-

IN ADDITION TO FOSTERING THE COOPERATION BETWEEN AGENCIES, THERE IS ALSO A NEED TO SEEK ADDITIONAL CONGRESSIONAL FUNDING. AT PRESENT, MOST AGENCIES ARE HEAVILY STRAINED BY THE RAPID GROWTH OF MULTIPLE SUBCULTURES AND IMMIGRANTS INTO THE LOS ANGELES AREA. CONGRESSIONAL FUNDING WOULD ALLOW PUBLIC AND PRIVATE SECTOR AGENCIES TO PROVIDE THESE BASIC SERVICES TO THOSE MOST IN NEED.

WITHIN THE EDUCATION AND JOB TRAINING RESOURCES AVAILABLE TO OUR DISTRICT, WE ARE PREPARED TO PARTICIPATE IN ANY INTERAGENCY COOPERATIVE EFFORT WHICH WILL HELP ALLEVIATE THE PLIGHT OF THE HOMELESS.

THANK YOU.

STATEMENT OF STEVEN M. PORTER, ASSISTANT GENERAL MANAGER, LOS ANGELES CITY COMMUNITY DEVELOPMENT DEPARTMENT

Mr. PORTER. Mr. Chairman, Honorable members, Councilman Bernardi. I am Steve Porter, Assistant General Manager for the City Community Development Department.

We are the administering entity of the federal block grants that are allocated on a formula basis from Washington to the City of Los Angeles. We were requested to panel today to discuss a pilot program which we put together a year and a half ago in response to a concept paper that was developed by the business labor council and presented to Councilman Gilbert Lindsey whereby the business labor council suggested utilizing some job training partnership act funds on a demonstration basis in the skid row area.

Since inception of the program in January of last year, the business labor council as a subcontractor to the United Auto Workers was contracted by the City to serve 58 homeless unemployed individuals on the row. And through a combined effort of this dual organization relationship, UAW, business labor council, store front relationships were established with two skid row transitional housing entities, one, Martha Brown Hicks transition house, and another run by Andy Robeson which was single room occupancy.

And over the 12-month period the contractor and business labor council were the assistants of the two transition houses, met all contract goals and did place in unsubdized jobs 58 individuals. We feel that while the strong demonstration program has been successful, a much larger effort is required to target employment needs of the homeless throughout the city.

And we are currently working with the major's office to recommend that the bonus funds that have been awarded to the city under the job training partnership act be utilized to take this pilot program that was available only to skid row residents and make it citywide, functioning in tandem with other transitional housing operations in the other five labor market planning areas of the city.

Chairman HAWKINS. Thank you.

The next witness is Robert Nelson, acting executive director of L.A. business labor council.

[Prepared statement of Steven M. Porter follows:]

Prepared Statement of Steven M. Porter, Assistant General Manager, Los Angeles Community Development Department

The Community Development (CDD) of the City of Los Angeles administers the Job Training Partnership Act (JTPA) program with policy guidance and direction from the Mayor, City Council and Private Industry Council (PIC). Approximately a year and a half ago, CDD was contacted by Councilman Gilbert Lindsay's Office (who represents the skid row area) to explore the possibility of an emergency demonstration employment and training program for homeless skid row residents. The Councilman had informally discussed some program concepts with an existing JTPA contractor who was providing various job training services to disadvantaged residents in the central area of Los Angeles. Given the intense interest already expressed by the Mayor and Council in transitioning homeless people to mainstream lifestyles, CDD met with the Mayor and received support for a unique sole source demonstration project with the Business Labor Council (BLC) for approximately $250,000 in Title III displaced worker funds to assist 58 homeless in obtaining fulltime unsubsidized jobs.

The Department established a task force comprised of existing skid row service providers to obtain their support and guidance in the design and development of the program. It was decided that the program should physically operate out of existing shelters and offer employment and training services tailored to the individual needs of unemployed residents of temporary shelters. Supportive assistance was offered by PIC organizations such as the Employment Development Department and the Department of Public Social Services. These linkages and specific support services were written into the contract as in-kind contributions. Although success of the program was initially threatened by the Business Labor Council's temporary closing due to loss of State funding, the CDD reformulated the contract by incorporating the Homeless Opportunity Program for Employment (HOPE) into the overall dislocated worker program administered by the United Auto Workers (UAW). Business Labor Council was reconstituted as the prime subcontractor of the homeless project, with a tighter program design whereby employment and training services were directly tied to two (2) temporary shelters on the row, Single Room Occupancy (under the direction of Mr. Andy Raubeson) and Transition House (managed by Ms. Martha Brown-Hicks who is also a PIC Board member).

The initial year of the HOPE program (1/1/86 - 12/31/86) was highly successful; fifty-eight (58) homeless were placed in jobs per the contract. The agreement has been extended through June, 1987; as of March 19, 1987 the UAW-BLC has already achieved forty percent (40%) of planned placements for this period (see attachment).

Given the initial albeit tentative success of this small pilot project, there is potential for expanding HOPE through modification of the existing contract to serve the homeless in the other five (5) labor market planning areas of the City. Although this expansion would represent a significant commitment and achievement within a two-year period, it could only provide direct comprehensive employment and training assistance to approximately three hundred and fifty (350) homeless at an annual cost of approximately 1.5 million dollars ($4,300 per participant).

If recent studies are correct in estimating that approximately twenty percent (20%) of the thirty-five thousand (35,000) homeless are employable with minor support, then this program if enlarged citywide would serve approximately five percent (5%) of those in need.

What is needed to reverse the current tragic trend of escalating homelessness is development and funding of a comprehensive intervention program targeted to assist and place the employable homeless into unsubsidized jobs that provide a living wage with ptotential for upward mobility into the primary labor market.

UNITED AUTO WORKERS

HOMELESS PROGRAM

The UAW Title III program for the homeless is also known as the HOPE Project. The current statistics for the HOPE Project's placements are as follows:

CONTRACT PERIOD	# OF PEOPLE CONTRACTED TO PLACE	# OF PEOPLE PLACED
1/1/86 - 12/31/86	58	58
1/1/86 - 6/30/87 EST.	58	23
		81 TOTAL

The Hope Project recruits from temporary shelters so that the participants the project serves are not representative of the total Homeless population. The following is a profile of the HOPE Project participants:

90%	Male
22-44 years old	Age Range
85%	H.S. graduates
2%	Offender
36%	Unemployed for 1-14 weeks
50%	Veterans
50%	Black

The average number of weeks participated for HOPE Project participants are 8 weeks.

Participants were placed in the following occupational fields:

Security
Social Services - Outreach workers
Retail
Maintenance

STATEMENT OF ROBERT NELSON, DEPUTY EXECUTIVE DIRECTOR OF LOS ANGELES BUSINESS LABOR COUNCIL

Mr. NELSON. Distinguished panel. Thank you very much for the invitation to be here. It has taken a partnership of a lot of agencies to make this hope employment and training project successful.

And they are basically the private industry council, the City of Los Angeles, the community development department the UAW labor employment training corporation, and the business labor council working with community agencies.

The program was funded for $240,000 with a lot of skepticism as to whether homeless people were one, employable, and number two, whether if they got a job, whether they would be able to be retained on the job.

Two organizations, however, were exceptional organizations which is the Skid Row Development Corporation which operates a transition house which is a major temporary housing facility but with extensive social service, and human service support systems.

And they have through JPTA funds established job search workshops, counseling, and actually gone out to the employer community and obtained employer commitments to hire these people, and have really gotten out there and did not believe that it cannot be done. They made it happen. On a more modest scale, also the SRO Housing Corporation.

So the goals which really are modest for the first year were made of 58 jobs, but I should say that the program did not really even begin until the middle of July so I know with what they now know they could do a lot more.

The average wage was $4.12. The type of occupations, 23 were security watchman, protective services, 15 maintenance workers clean-up crews; 6 at retail sales, 5 in social services for the homeless; 4 in jobs in existing shelters.

Evaluating and looking at it from the standpoint of both the UAW and the business labor council that we believe that projects like this can only be mounted, can only be successful if it has organizations like the Skid Row Development Corporation with their network of support services, or the SRO Housing Corporation. But that it probably can be replicated and expanded on a much greater scale.

And one of the things to remember in these—in the programs at Skid Row Development Corporation is that the individuals doing the employment training services are 100 percent dedicated to the improvement of a lot of the clients. And they have a very, very, special esprit de corps that they have established in their clientele that they want to make it, and they want to clothe themselves, and motivation is a tremendous key.

By the time the job development people and their counselors finish with them, those employers are willing to listen and are willing to hire. So we are very proud of that.

Chairman HAWKINS. The next witness we are very pleased to welcome and to introduce, Ms. Martha Brown Hicks, president of Skid Row Development Corporation.

[Prepared statement of Robert Nelson follows:]

UAW
LABOR EMPLOYMENT
and
TRAINING CORPORATION

A TOTAL JOB DEVELOPMENT AND TRAINING SYSTEM

PRESIDENT & CEO
Bruce Lee

BOARD OF DIRECTORS
Sol Bainky
Richard Boyle
Frank Chabre
Leslie Clark
Don Ephlin
Henry C. Gonzalez
Raymond Majerus
Marc Stepp
John Szymanski

EXECUTIVE DIRECTOR
Ronald J. Post

TESTIMONY OF ROBERT NELSON, DEPUTY EXECUTIVE DIRECTOR OF THE LOS ANGELES BUSINESS LABOR COUNCIL ON THE HOMELESS EMPLOYMENT PROGRAM ON SKID ROW.

The UAW - Labor Employment and Training Corporation in conjunction with the Los Angeles Community Development, the City of Los Angeles Private Industry Council and the Los Angeles Business Labor Council has established Homeless Opportunity Program for Employment in 1986 (Project Hope).

Through the use of Job Training Partnership Act Title III funds, program was allocated approximately $240.00 to provide employment training services and place into unsubsidized jobs approximately 58 homeless persons from Los Angeles Skid Row. The responsibility of establishing the services delivery system is the responsibility of the Los Angeles Business Labor Council as the major coordinating agency in the UAW - LETC City of Los Angeles Title III contract.

DELIVERY SYSTEM

The service providers and their respective role in the delivery system are as follows:

1. Skid Row Development Corporation, operates Transition House a major temporary housing facility with an extensive program of human and social services. Through JTPA funds, Transition House provides client outreach, intake, counseling, job search assistance workshops, job development with area wide employers and job referral and placements.

2. SRO Housing Corporation operates housing facilities in hotels that have rehabilitated to provide numerous cost on subsidized shelter, with an extensive human and social services. Through JTPA funds, SRO provides clients counseling job search assistance and job placement.

3. LABLC coordinates on the job training with employers for clients identified by SRO and SRDC.

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PROJECT RESULTS

The program goal for 1986, was the placement into non-subsidized jobs, and retention on those jobs for at least 31 days of 58 homeless. As of December 31, 1986, 58 participants have retained, representing a 100% attainment of goal.

AVERAGE WAGE ALLOWED

The project goal was $4.58 per hour upon placement. As of 12/31/86 the average placement wage is $4.20, some what less than the goal.

ACTIVITIES

Job Search Assistance and Placement - 51 retentions
On-the-Job Training - 7 retentions

TYPE OF OCCUPATIONS

Clients were placed into 5 major occupations as follows:

23 - Security, watchmen, protective services.
15 - Maintenance workers, clean up crews.
6 - Retail sales.
5 - Social services for the homeless.
4 - Jobs in existing Skid Row shelters.
5 - others.

EVALUATION

Even though the number of retention is modest, and we have not tracked the large number of people who have received job search assistance and not been placed in jobs, still the program does represent a qualified successful beginning. With the assistance of caring dedicated and professional employment training staff, homeless can be assisted to return to work, and hopefully get back on the road to self sufficiency.

In our opinion, the reason for the sucess of the Hope project is the selection of the Skid Row Development Corporation and SRO Housing. As service deliverers. Both agencies already provide, or have located in their facilities a great array of supportive services including shelter, meals, mental health services, county social services and counseling. Both programs put a great stress on self help, and have created an environment of committment to acheiving re-entry into mainstream society.

The clients that enter the JTPA program are job ready motivationally, and with the support of the job developers and job counselors are prepared to be acceptable to the employment community. Without, however the support services of these agencies, the Hope project could not succeed.

THE FUTURE

For the six months from January to June 30, 1987, there are sufficient funds in the contract to continue the project Hope effort. Currently, the City is processing an extention to utilize these funds for another 58 retentions. In January and February the Project has acheived an additional 21 retentions.

Beyond June 30, 1987, funds would be needed to continue the project. The project can be expanded to other areas of the city where there are effective organizations that provide services to the homeless. We would welcome working with them to establish the program there.

STATEMENT OF MARTHA BROWN HICKS, PRESIDENT OF SKID ROW DEVELOPMENT CORP.

Ms. HICKS. Members of the distinguished panel. I am delighted to be here. The only one of you that I do not know personally is Mr. Martinez. I might say that I have had the privilege of working very closely from the beginning of the corporation with Congressman Roybal, Congressman Hawkins, and with Councilman Bernardi.

They have been to visit our facility, and as you know the Skid Row Development Corporation operates transition house and we also do economic development to fund the more noble things that we do.

Transition house, incidentally, we see the international year of the homeless award this year given by the United States Department of Housing and Urban Development. I will stay within my time frame and discuss transition house programs and the employment component.

There are a variety of programs functioning at transition house. The job preparation program is mandatory for all 130 residents unemployed. This group meets once a week. Those residents having difficulty deciding to seek employment are placed in a more intense group which will meet seven days per week.

Alcoholics Anonymous meets twice a week. Residents identified as having alcohol problems must attend. Narcotics Anonymous meets once a week. Two therapy groups conducted by mental health professionals meet twice a week. An informational film is shown every Friday to address different topics, drug use, alcoholism, health issues, this meeting is mandatory for all residents.

The Monday night house meeting with mandatory attendance for all residents is geared to address the responsibilities of the facility to the residents. Responsibility of the residents to the facility as well as to themselves.

The specialized shelter project for the homeless mentally ill. House details are mandatory for all residents. Many residents come to skid row to avoid responsibility.

We attempt to reintroduce responsibility to them. We try to communicate the feeling that they are competent, constructive and reliable human beings. We provide a safe clean environment. We connect them with health clinics, mental health clinics, advocacy groups and whatever is necessary.

We provide stability and job preparation training. The job program functions in the following manner. Residents admitted to transition house are eligible for participation in the job program. Upon admission, they are interviewed to determine their work experience, interest and attitudes toward work. All residents were unemployed and or not work full time 32 hours per week or more, must attend a weekly pre-employment group.

This group meets every Wednesday at 8:00 p.m. Residents are given the benefit of instructions in job search skills, development of an individualized job search plan, instructions in interview techniques, preparation of resumes and completion of job application forms.

Based upon the results of this pre-employment and assessment activity those participants were deemed employable and with mar-

ketable job skills are matched with job openings identified by transition house.

From the period of May 1986 through November 1986, 165 residents have been helped to secure gainful employment. The average wage scale has been $4.00 per hour. All jobs are verified and documented by the employee's supervisor. Certain documentation must be secured prior to submission for payment from Project Hope, such as birth certificates, DDT-214 for military service if applicable.

We have experienced some breakdown concerning the birth certificates, however, we are in the process of straightening this out. Persons identified as having problems which prevent successful participation in the program and therefore cannot be properly be serviced by this program are referred to the appropriate agency for the necessary services.

This program contains a reimbursement rate that is dependent upon the rate of pay for hour for the individual who is placed. The minimum reimbursment to the Skid Row Development Corp. through transition house is $1,500 per person for a beginning rate of $4.01 per hour.

For a placement of $5.00 per hour, the reimbursement rate is $2,376, and we are reimbursed by the business labor council through the private industry council, the PIC. We urge continuation or expansion of this program because it seems to be successful.

I think I am under my time quickly so I would just like to add this. For those of you who may be designing or assisting with the congressional appropriation for homelessness, I would urge you to consider money for operations not just the development of new shelters.

We face the real problem and almost closed down this model shelter just before the HUD people came out to look at the facility as we got the award because we did not receive a state grant. The state emergency shelter program gives priority to shelter development which means while we had an excellent application, we fell very low on the scale because of shelter development.

It is a critical problem to provide some set asides for operation of—for continuing operations that have been evaluated and work successfully in addition to developing new shelters. Thank you for your cooperation.

Chairman HAWKINS. Well, thank you, Mrs. Hicks.

The next witness is Nancy Mintie, director, Inner City Law Center.

[Prepared statement of Martha Hicks follows:]

PREPARED STATEMENT OF MARTHA BROWN HICKS, PRESIDENT, SKID ROW DEVELOPMENT CORP

TRANSITION HOUSE PROGRAMS --- EMPLOYMENT COMPONENT

There are a variety of programs functioning at Transition House.

1.) The job preparation program is mandatory for all residents unemployed. This group meets once a week. Those residents having difficulty deciding to seek employment are placed in a more intense group which will meet seven days per week.

2.) Alcoholics Anonymous meets here twice a week. Residents identified as having alcohol problems must attend.

3.) Narcotics Anonymous meets once a week.

4.) Two therapy groups conducted by mental health professionals meet twice a week.

5.) An informational film is shown every Friday to address different topics: drug use, alcoholism, health issues, etc. This meeting is mandatory for all residents.

6.) The Monday Night House Meeting with mandatory attendance for all residents is geared to address the responsibility of the Facility to the residents, the responsibility of the residents to the Facility, as well as to themselves.

7.) The Specialized Shelter Project for the Homeless Mentally Ill.

8.) House details are mandatory for all residents. Many residents come to Skid Row to avoid responsibility. We attempt to re-introduce responsibility to them. We try to communicate the feeling that they are competent, constructive, and reliable human beings.

We provide a safe, clean environment. We connect them with health clinics, mental health clinics, advocacy groups, and whatever is needed. We provide stability and job preparation training. These things create a sort of curative therapeutic milieu.

The Job Program functions in the following manner:

Residents admitted to Transition House are eligible for participation in the Job Program. Upon admission they are interviewed to determine their work experience, interest and attitudes toward work.

All residents who are unemployed and/or do not work full-time (32 hours per week or more) must attend a weekly pre-employment group. This group meets every Wednesday at 8:00 p.m. Residents are given the benefits of instructions in job search skills, development of an individualized job search plan, instructions in interview techniques, preparation of resumes and completion of job application forms.

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Skid Row Development Corporation

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BIO SKETCH

Martha Brown Hicks

Martha Brown Hicks is President of the Skid Row Development Corporation. The Corporation shelters 268 people nightly, 130 at Transition House and 138 at the Temporary Emergency Shelter. They also do economic development through two commercial/light industrial centers totaling over 100,000 square feet of space to provide jobs and generate revenues for Transition House.

STATEMENT OF NANCY MINTIE, INNER CITY LAW CENTER

Ms. MINTIE. Thank you, members of the distinguished panel and Councilman Bernardi.

For the past seven years, I have been the director of the Inner City Law Center which serves approximately 300 clients per month in the skid row district of downtown Los Angeles. The majority of our clients are homeless or have recently been homeless.

I would like to talk to you today about a federally funded jobs program here in Los Angeles that went terribly awry. In fact, it was a program that created more homelessness than we had to begin with.

And I want to do this because I think that being frank with you perhaps we can avoid recreating some of the mistakes of the past.

Now, the program that I am referring to is one that was run by the county of Los Angeles in 1983 and 1984 with federal JTP funds and was designed to be a job training program for homeless people.

Now, the county had an interesting idea for how to use these JTPA funds. Normally, the county is supposed to be providing for the welfare of the indigent people in this area. State law requires them to do so out of their own funds. And in the past, they have done that through the general relief system or the GR system which is our local social service safety program for homeless people. Under this program a person, an abled body person works for the county and earns their $247 a month grant.

Now, the county's idea to save some money was this. They were going to take all 17,000 able bodied homeless people that were participating in this county program and cut them off. Then they were going to turn around and tell these people in order to continue receiving the benefits that you depend upon for your survival, you are going to have to participate in this job training program.

And then the county was going to take the JPTA funds set up a "job training program" and dump all those 17,000 people into that program and use that money for the support of these individuals. Now, by this plan the county would take those 17,000 individuals off of their welfare roles and dump them on you, the federal government.

Well, the county go so excited about this plan that in September of 1983, it cut off all 17,000 of those able bodied people before they had even established a plan under the JTPA funded program, before they even had an alternative system to support these people.

And so for about a month period there was no program at all here in Los Angeles to help and support these people, and 4,000 people in that month fell through the cracks and disappeared.

Now, I can tell you what happened to those people. Because they were on the welfare roles here in Los Angeles County that meant that by definition they had to be absolutely indigent. You can't receive welfare here in Los Angeles County if you have more than $50.

Actually, there is one exception. If you spent your last $500 on your own burial crypt to save the county from the expense of cremating you upon your death, then you can still qualify for the welfare program.

But if you have more than $50 and a burial crypt, you cannot be on welfare. So when these people were cut off and I know because I was working with this population at the time the majority of them joined the ranks of the homeless that were swelling the mission lines and soup lines in the streets of Los Angeles that fall.

Now, that was just the beginning. The new program was supposed to provide both job training and support for these 17,000 individuals, but through an incredible amount of bureacratic bungling and mismanagement, it not only did not provide effective job training, but it did not even provide support for many, many of these people.

In fact, 2,000 people a month on the average under this program fell through the cracks because their files were lost, because the paperwork was mismanaged, because of bureacratic mismanagement on the part of the county.

Now, these people did not go away, and they certainly did not get jobs. No, these people as well became homeless and ended up on my doorstep.

Now, in fact, if the consequences of this program had not been so tragic, it would have been comical. I will just give you a few examples. Some of our clients who were English speaking were sent to Spanish classes for training. Others who spoke Spanish were sent to Chinese classes. There was sort of a musical chair of nationalities going around.

Some were sent to classrooms where no teacher ever showed up and yet they were forced to sit there for the entire duration of the training. Others were told to buy books and uniforms for the classes but given no money to do so. Our illiterate clients were sent to word processing classes.

People were trained for jobs that did not even exist. My favorite one was that they took 700 of these folks, they put them in classes to learn how to repair manual typewriters. Now, my office did a little sample phone survey. We called up around Los Angeles and found that less than 1 percent of the businesses in the area even have manual typewriters, and yet these people, their hopes were getting up, they were being trained for these jobs that did not even exist.

In fact, the county only contracted for 1,800 training slots, and so the remainder of those 17,000 people were given no training whatsoever under this "program." There were no written guidelines or procedures.

And so a very important right, such as the right to a hearing before your benefits are cut off was denied. There was no hearing. Actually, there was a hearing. Do you know what the hearing consisted of? Before your benefits were cut off and you were turned out into the street, they would herd 20 or 30 individuals, participants into a hallway of a government office building, a county worker would come out and say, okay, here is your hearing. And then all 20 or 30 people at the same time were supposed to fend for themselves and mob this worker and explain why they should be reinstated in the program.

Well, it was not even a kangaroo court. Now, based upon our sad experience with this program, and also on my seven years of experience in working with homeless people in the city, I would like to

make three just very simple and brief suggestions about programs for the future, elements that I think are very important.

I think in the future money for federal—federal money for job training and job placement for the homeless cannot simply be handed over to our county board of supervisors not without very comprehensive federal standards and enforcement of those standards which force the county to be accountable to you folks, so that you know and that we receive a responsible and effective program.

Or better yet, that money should go to private non-profit organizations that have an established record for actually providing job training successfully to homeless people.

Second point. No program can be a success unless our folks are guaranteed that their basic survival needs will be met for the duration of that program until they get that job. They have got to have secure housing, they have got to have food, they have got to have the laundry services, phone and mail services, clothing, even some health services.

I had one client who did not have eye glasses and was very nearsighted. He would go out to apply for a job, go into an employer, take a job application and say, excuse me, I am going to go outside and fill this out. Then he would go out on the sidewalk and try and buttonhole strangers until he could find someone who would fill out the job application for him all because there was no provision for him to get eyeglasses, which of course considerably hampered his job search.

Final point. Training programs have got to be geared toward jobs which actually exist here locally, and we have got to make sure that training is appropriate for the people who actually comprise our homeless population. And in conclusion I would like to say that my intent is certainly not to oppose programs like the JTPA program. I support them. I think they should be increased for our homeless people here.

I simply think that we need to have more accountability built into the programs. There has got to be a way for you gentlemen to make sure that that money that you are allocating for these programs is used wisely and in fact gives our homeless people a chance to get that job and get back into a productive life in our community.

Thank you very much. [Applause.]

Chairman HAWKINS. Thank you. Mr. Martinez? Mr. Roybal?

Mr. ROYBAL. Mr. Chairman, due to the lack of time that we have I will not ask any questions. However, I wonder if I were to submit questions in writing at least one apiece, if you would be kind enough to answer those questions in writing.

Mr. Chairman, I ask that the record be kept open for an additional 30 days, or 30 days from now so that we can in fact submit questions to the witnesses and they in turn can answer.

Chairman HAWKINS. Without objection, so ordered.

Well, Ms. Mintie, I think your statement is quite explicit. As I recall the education and labor committee through its subcommittee did investigate the County of Los Angeles in 1983, was it not?

Mr. ROYBAL. Yes, it is.

Chairman HAWKINS. And we were assured of some things that are in direct conflict with what you have charged, and which if

true certainly constitute a violation of the commitments made to us in 1983. I will consult with the chairman of that subcommittee now, Mr. Martinez, when we return to Washington, and we will certainly have to consider the statements made by you again contact the County of Los Angeles for an explanation of the statement that you have made.

I can assure you that we will leave no stone unturned to make sure all of the facts are brought out because it constitutes a rather serious violation of federal law if any substantial number of the charges you have made happen to be true.

Ms. MINTIE. Thank you, Chairman Hawkins. I would be very happy to provide you with any further documentation of any of those statements that you would require.

Chairman HAWKINS. We will consult with you and assure you of cooperation of the committee because we are seriously concerned with the operation of the job training partnership act, and we were concerned in 1983. But apparently we did not follow up as carefully as we should have done, but I can assure you we will look thoroughly into the problem now.

Mr. ROYBAL. If the Chair will yield, that is the reason why I asked that we submit the questions in writing, so that there would be specific, they will be in writing, and that they be answered properly. I think that that is probably another way of proceeding.

Chairman HAWKINS. We would ask the county to respond in the same manner. Councilman.

Mr. BERNARDI. She is very reliable.

Ms. MINTIE. Thank you.

Chairman HAWKINS. We are not disposed to give strong opinion, but I will reserve my opinion today, and assure you of our continuing cooperation with you involving the charges that you have made.

Mr. Martinez.

Mr. MARTINEZ. The Chairman said we did hold hearings in 1983, and we were aware of those kinds of violations. Chairman Hawkins strongly emphasized that they were in violation of the laws.

They assured us at that time that they were not going to do exactly what they had contemplated doing. It seems now that they went ahead and did that anyway. I share the Chairman's concerns and we on the Subcommittee on Employment Opportunities will be in touch with you to follow this up.

Chairman HAWKINS. As I recall, we did ask a state investigation, to stay clear of the County of Los Angeles of any wrongdoing, and perhaps we had better include the state also in any inquiry that we make because they assured us that they followed up at other hearings, had cleared the county of Los Angeles of any wrongdoing.

But if they were terminated before a plan was in operation, that itself was a serious violation. Thank you. No further questions? We express the appreciation of the committee for the very excellent statements made by the members of the panel.

[Prepared statement of Nancy Mintie follows:]

PREPARED STATEMENT OF NANCY MINTIE, INNER CITY LAW CENTER, LOS ANGELES, CA

A CAUTIONARY REVIEW OF THE HISTORY OF LOS ANGELES COUNTY'S USE OF JOB TRAINING PARTNERSHIP ACT FUNDS FOR THE HOMELESS

Chairman Roybal, Chairman Hawkins and Chairman Martinez:

Thank you for the opportunity to present testimony at this Congressional hearing on jobs and job training for the homeless.

INTRODUCTION

My name is Nancy Mintie. I am an attorney and for the past seven years have directed the Inner City Law Center, a free legal assistance agency for the homeless and the ill-housed of central Los Angeles. Our center serves approximately three hundred clients per month, the majority of whom are homeless or recently homeless.

The employment of the homeless has been a long time concern of the Inner City Law Center. In the summer of 1982 we conducted a job clinic for our homeless clients. In 1983 and 1984 we represented hundreds of indigent people affected by an employment program administered by Los Angeles County with federal Job Training Partnership Act (JTPA) funds.

The purpose of my testimony is to expose how the county's bureaucratic mismanagement of these federal job training funds resulted in widespread suffering among the indigent and how this mismanagement actually became one of the leading causes of homelessness itself in Los Angeles.

HISTORY

To properly understand employment issues or any other issue affecting the homeless in Los Angeles, it is necessary also to understand the role of the General Relief program, or "GR." General Relief is the social service "safety net" program for the homeless in Los Angeles. It is a workfare program administered and funded by the county pursuant to its statutory duty under California's Welfare and Institutions Code section 17,000 et seq. to relieve and support the indigent. Under the GR program, all able-bodied homeless individuals are required to perform menial labor for the county in return for their grant of $247 per month.

In September of 1983, the County of Los Angeles, in a cost saving measure, terminated the benefits of all of the approximately 17,000 able-bodied participants in the General Relief program. The county Department of Public Social Services announced its intent to transfer all of these individuals into a job training

program the following month that would be run with federal JTPA funds. This transfer permitted the county to avoid its statutory duty to financially support these 17,000 people by substituting federal funding for their support.

However, at the time that these 17,000 individuals were terminated, no job training program was in place and no alternative program was available to support these indigent people, who depended upon the program for their food and shelter. As a result of the gap in programs, by October, when the county Department of Community Services (DCS) announced the beginnings of its job training and support program, four thousand people already had been lost in the paperwork transfer between the old GR program and the new jobs program. These four thousand former GR recipients by definition had no other resources, and so the majority of them joined the ranks of the homeless who were swelling the soup lines and mission lines that fall.

Once begun, the new jobs program was so inadequate and so poorly managed that it continued to "lose" the case files and consequently deny benefits to two thousand indigent individuals each month who had no other place to turn but the street. Consequently, through misuse of federal job training funds, the county itself became the single greatest cause of homelessness in Los Angeles for the duration of this ill-conceived program.

This alleged job training and support program established with JTPA funding was called the Specialized Career Rehabilitation Program. It was administered by the County Department of Community Services (DCS) from its inception in October of 1983 until it collapsed approximately ten months later under the weight of its own internal problems and litigation that had been filed against it. (Venzor v. County of Los Angeles, Los Angeles Superior Court)

The following is a partial itemization of the problems encountered by our clients with this job training program:

1. The 17,000 people who initially had been transferred into the job program, formerly had received their support through the GR program. In that GR program, two hundred case workers had been available to handle problems that arose in individual cases. For the first few months of the new job program, however, no staff was assigned responsibility for resolving the many problems that inevitably arose among the 17,000 participants. Ultimately, only two staff persons were assigned to deal with individual problems. This, of course, represented a drastic reduction from the two hundred case workers that formerly had served this population. As a result, thousands of eligible participants were terminated when complications arose in their cases, simply because of a lack of personnel to resolve those problems. Because these participants depended on the program not only for job training but for their livelihood as well, most of these individuals became homeless upon termination from the program.

2. Lack of an adequate record keeping, and information storage and retrieval system, resulted in countless paperwork errors on the part of the Department of Community Services. Instructions to program participants were mailed to incorrect addresses. Participants were issued incorrect directions to classes. Benefits were cut off from individuals without reason. Case files were lost for weeks at a time, sometimes even permanently. Checks were not mailed to participants for months at a time and then often were issued for less than the amount owed to the person. Yet each of these paperwork errors was blamed upon the participant and resulted in that person's termination from the program and loss of benefits.

3. The students enrolled in the mandatory job training classes were given requirements that they could not complete. Some were told that they had to buy books and supplies for the classes, but even though they were indigent, they were given no money with which to purchase these items. Others were told to meet a dress code but were not given funds to buy decent clothing. Many of the students had to reside in the cheap slum housing of downtown Los Angeles but were assigned to classes in outlying areas. They were given twenty dollars for a bus pass, but in two installments, one at the beginning and one in the middle of the month. Consequently, for the first half of each month, they had insufficient money for transportation to the trainings. Lack of compliance with these unreasonable requirements was ground for termination from the program and loss of the benefits needed for survival.

4. Students were assigned to inadequate or inappropriate classes. Many of our English speaking clients were assigned to "English as a Second Language" classes. Others were sent to classes taught in a foreign language. Many were sent to trainings in which no instructor appeared, but nevertheless they were forced to sit in the empty classroom for the duration of the training period. Others were enrolled in classes which taught skills for which no jobs were available in the local economy. For example, hundreds of participants were trained to repair manual typewriters. My office conducted a sample telephone survey of local businesses and found that less than one percent of the businesses in Los Angeles used manual typewriters. Others were sent to classes in areas such as finance credit and word processing, which were completely unrealistic for what is largely a semi-literate and illiterate population of indigents.

5. The job program suffered from a lack of written guidelines and procedural protections. Consequently, the recipients were extremely confused about their rights and responsibilities under the program since they often had no information except for incomplete or contradictory oral instructions. One of the most important rights that was lost under this program was the right to a fair hearing before one's benefits were terminated. My office alone saw dozens

of clients who had received arbitrary termination notices which should have been subject to challenge. However, the "hearing" that was offered consisted of twenty to thirty terminated recipients being crowded into a hallway of a government office building. Then one DCS worker would come out and announce that this gathering constituted the entire group's "hearing." My advocates then would have to resort to cornering the DCS staff person and trying to lobby on behalf of all twenty or thirty individuals in the hall at the same time. Other clients were given no notice at all and only learned that they had been terminated from the program when their checks stopped coming and they were evicted for lack of ability to keep up their rent payments.

6. Once the job program had been fully established, even then it was too small to handle the 17,000 participants. For example, two months into the program, approximately ten thousand people had not been assigned to classes at all because the county had not contracted for enough training slots. Of these, four thousand were assigned to unskilled menial labor tasks benefiting the county but having no training value for the individual. Another six hundred people had been assigned to training slots which did not exist because many training providers were assigned more students than the number of available classroom openings in their programs. At that time, only 1,800 of the original pool of 17,000 individuals were receiving any kind of training whatsoever under this program.

In the years following the demise of this disastrous job program in mid 1984, I have heard individual members of the Board of Supervisors of the county claim that the program was a success. I know of no factual basis for this claim. Perhaps it was considered a success because through losing case files, creating impossible bureaucratic hurdles and countless arbitrary terminations, the county succeeded in removing thousands of indigent people from the government aid rolls. However, as the director of a program serving this same impoverished population at that time, I can testify that the great majority of the thousands of people who lost their benefits, joined the ranks of the homeless, not the ranks of the employed.

RECOMMENDATIONS FOR THE FUTURE

After more than seven years of working on a personal and daily basis with the homeless of Los Angeles, I know that there are several prerequisites for a successful job training program targeted for this population. At a minimum, the following elements must be considered:

1. Federal funds for job training and placement for the homeless should not be administered by the County of Los Angeles unless the funds are accompanied by comprehensive and mandatory federal standards which are strictly enforced to ensure that an effective and appropriate program is established. Ideally, such funding should be allocated to reputable private nonprofit organizations that have a demonstrated track record for administering job programs for the homeless.

2. No job program for the homeless will be effective unless it guarantees that basic personal needs will be met until employment is obtained. These needs include:

-secure housing
-an adequate diet
-decent clothing
-accessible facilities for laundering and ironing
-personal needs items such as razors and combs
-a place to receive mail and access to a telephone for job searches
-transportation for job searches and travelling to interviews
-in many cases, eyeglasses, dental care or other forms of health care will be required

3. Job training must be appropriate for the homeless population and be geared toward jobs which actually are available in the local economy. Wide scale training for jobs requiring a high degree of literacy will not be useful for the homeless population, the majority of whom are semi-literate at best. In addition, training individuals for jobs which do not exist, such as manual typewriter repair, is nothing more than a cruel hoax. Special subgroups of the homeless, such as the mentally disabled, will have special training and employment needs as well, such as a sheltered workshop environment.

CONCLUSION

Though I have attempted to bring to light an example of a particularly poor use of federal job program funds, I do not mean to belittle such programs for the homeless. On the contrary, I believe that funding such as that provided by the Job Training Partnership Act should be continued and even increased. However, to be truly helpful for the homeless of Los Angeles, these funds cannot be entrusted blindly to the county. Rather, Congress should take additional care to ensure that funding that is made available for jobs programs is actually used to create effective programs resulting in real jobs that will break the cycle of poverty and return the homeless to productive and dignified lives in our communities.

Chairman HAWKINS. Mr. Silva, I don't know how much time you can have on the schedule, but if you do not—well, may I say a statement can be filed, and it will be in the official record.

I cannot allocate time until I have listened to the rest of the witnesses, but I assure you the least that will be done and you will have an opportunity to officially present the statement and have it included in the record.

The next witness is Mr. Bruce Monroe, President of Crime Prevention through Substance Abuse Treatment. Mr. Monroe, we welcome you.

STATEMENT OF BRUCE MONROE, PRESIDENT OF CRIME PREVENTION THROUGH SUBSTANCE ABUSE TREATMENT

Mr. MONROE. Distinguished panel, thank you for the opportunity to testify.

I come describing a new program that is right down the block from the Weingart Center, from transition house, and the inner city law center. We are the next building down the block, and as the name applies, we are treating substance abusers in order to prevent crime.

We have a 2-year long comprehensive program in three stages. And it is the third stage of that program that may be of interest to you gentleman. And I have asked the chairman of our economic development committee, Mr. Buddy Nadler, to describe our third stage and some rather non-traditional ideas about employment of criminals, substance abusers and homeless.

Buddy Nadler.

[Prepared statement of Bruce Monroe follows:]

PREPARED STATEMENT OF BRUCE MONROE, PRESIDENT OF CRIME PREVENTION THROUGH SUBSTANCE ABUSE TREATMENT

My name is Bruce Monroe. I live at 640 Seabreeze, Seal Beach, CA, and am testifying on behalf of CPTSAT, INC. (Crime Prevention Through Substance Abuse Treatment) a non-profit, public benifit consortium of 7 law enforcement agencies, the medical community, government organizations and related social service agencies. The attatched material describes our program. I have brought with me Buddy Nadler, 3721 Westwood Boulevard, Los Angeles, CA, Chairman of the Economic Development Committee of CPTSAT.

We view economic development as critical to long range solutions to homelessness, crime and substance abuse. We propose the Congress give leadership to similar programs in every urban area with concentrations of homeless people. Our organization proposes that the Congress consider creating enterprise zones in urban areas with homeless populations. We suggest that a coalition of government and business interests incubate small businesses made up of labor cooperatives formed by homeless people and those attempting to help them. These coalitions would plan, organize, develop and incubate small businesses who would be given SBA loans - a series of SBA loans, if necessary - and continuing, long term technical assistance to insure those businesses ultimately succeed.

Those of us active in the Skid Row area have a vision of a transformed Los Angeles basin - particularly the inner-city - with less crime, adequate shelter, greater prosperity, happy families and deserted jails. Our vision, stated in our mission statement, is as follows:

> "The mission of TURNAROUND is to develop productive recovering addicts and groups of recovering addicts...rooted in health, personal growth and business sense...to compete successfully in the free market as small business partners.
>
> Our objective is to provide the tools and means by which groups of people work for themselves and work in harmony with others.
>
> As a result, former substance abusers become productive business partners and the urban "swamps" begin to disappear."

526 S. San Pedro, Los Angeles, CA 90013 (213) 623-HELP
An affiliate of CPTSAT Inc. A non-profit, public benefit corporation.

We believe that our program here in Los Angeles could become a national model for a partial solution to the need for full employment for the homeless. Standing in the way of the accomplishment of this dream are misunderstandings, fear, frustration, desparation, bigotry, bias, bureaucracy, complacency, out of date concepts and a lack of Congressional and executive leadership. One such out of date concept is the concept of "jobs" and "job training." Jobs for the homeless never have been, and never will be, a permanent solution. A more enlightened concept is the concept of Labor Entreprenuership creating jobs from which they can never be fired and in which they will labor, strive and work twice as hard on behalf of their own self interest than they ever would to satisfy an employer's demands. Groups working shoulder to shoulder for an insured future in which they have personal pride of accomplishment are a vastly superior alternative to another CETA program.

Our program is dealing with these roadblocks in a new program on Skid Row called the TURNAROUND ALTERNATIVE TREATMENT CENTER. This outpatient detox clinic, coupled with a self-help group program, is beginning the process of incubating small businesses and worker owned cooperatives in the tradition of AMANA, U.P.S., AND PEOPLE EXPRESS. DELANCY STREET, too, but they are residential.

What we propose will not necessarily work for all the homeless. But for those groups who are most highly motivated; encouragement, guidance and resources such as we provide, will reduce the problem. For the less motivated, Delancy Street type programs should be second in priority. Perhaps a minority of the homeless may require sheltering and sheltered workshop jobs. But we argue against the dependance created by this type of alternative. We argue very strongly that dealing with each homeless person as an individual, and attending only to their short term needs, has only perpetuated the problem. Organizing groups, and nurturing groups to help themselves to help one another in the struggle for collective, long term success, is a more potentially successful solution and will be more cost effective since it is a one time investment in the problem.

encl: Overview & newspaper articles

CRIME PREVENTION THROUGH SUBSTANCE ABUSE TREATMENT (CPTSAT)

OVERVIEW

Purpose

To prevent crime by successfully treating hardcore criminal substance abusers, and organizing their recovery in such a way that the crime rate is reduced. To provide a vehicle whereby narcotic abusers can reenter society and become productive citizens.

Social Trends and Research Findings

There is a growing epidemic of substance abuse and related crime. Current methods of threating criminal substance abusers has had very little long-term success because of the psychological impact of incarceration and resource limitations. The medical specialty of behavioral medicine helps the typical patient to recovery, if multi-year effective support groups support recovery. Recovering abuser groups must gradually become physically, socially, spiritually and economically self-sufficient. Oriental behavioral medicine is more cost-effective than Western behavioral medicine. Abusers must choose among treatment options initially, and functions as equal permanent "partners" in the treatment plan and recovery process - over the long haul - to develop new lifestyles.

It is acknowledged by law enforcement experts that as much as 90% of urban crime is drug or alcohol related. This may take the form of crimes committed to support a habit, crimes committed under the influence, or crimes resulting from the illegal distribution of drugs. The New York program for the treatment of hardcore substance abuse has been in effect in New York City at the Lincoln Hospital for more than eleven years. Not only is the program cost-effective, but has also been self-supporting. This project will evaluate its effectiveness in the Los Angeles environment. Our research-based expansion of the New York program will include social self-help groups and an economic cooperative.

Organization and Roles

Public/Private Partnerships are increasingly popular and successful. A multi-agency, multi-organization "systems" plan and development is necessary because of the complexity of the necessary solutions, and the recources available.

During its initial phase the project will be under the direction of a Steering Committee comprised of representatives to the Los Angeles Police Department, The Los Angeles County Sheriff's Department, the District Attorney's Office, the Probation Department, the State Attorney General's Office, the health care industry, volunteers, and agencies with necessary expertise.

Key to the staffing is the presumption that the appropriate place to develop the project is adjacent to a social agency in the Skid Row area, and that existing staff will be able to coordinate some intake and record keeping functions.

Treatment Protocol Options

1. Developing bonding through the formation of "partnerships" and "families" utilizing behavioral contracts with both individuals and groups.

2. Self-help support group meetings and follow-up activities.

3. Ear acupuncture detoxification and follow-up maintenance and long term recovery treatments.

4. Nutritional counseling.

5. Exercise, movement therapy, and stress reduction via mediation, yoga, relaxation, etc.

6. Herbal preparations

7. Instruction in survival skills and job skills.

8. Reeducation and resocialization through self help group process training.

9. Guidance in finding assistance, resources and cooperation from individuals and agencies outside the CPSAT organization.

10. Public service work and career counseling.

11. Cooperative ventures and business operations.

12. Family and peer counseling as required.

13. Advocacy and/or ombudsman services with other organization on behalf of Turnaround participants.

14. An experimental component(s) for easy evaluation of additional treatment modalities.

Timetable

1. Phase I, June, 1986, for approximately six month trial and evaluation, Plan Phase II.

2. Phase II, 1986-87, expand to regional satellite locations, operate for approximately two years. Plan Phase IV phaseout, turnkey licensing/franchise in health care companies. Facilitate franchising to cooperative.

3. Phase III, expand to selected Statewide locations, operate for approximately two years. Plan Phase IV phaseout, turnkey licensing/franchise in health care, insurance and social services industries.

4. Phase IV, issue RFPs for privatization, license selects international health care compnies. Facilitate franchising to cooperative.

Resources

During the pilot project, all resources will be either volunteered, donated or absorbed by existing programs.

Project Management: The Project Manager will be Dr. Michael Smith, Director of the New York Project. His West Coast counterparts will be Dr. John Clark and/or Bruce Monroe.

A Steering Committee will provide input for the management of the project.

The physical facility will ideally be located at 526 South San Pedro Street. A sattelite clinic is open at 615 South Westlake. Other locations are being considered in high crime/abuse areas.

Acupuncture Therapists have already been trained by Dr. Smith and have volunteered their services without cost for this experimental program. They will be certified by the National Acupuncture Detoxification Association. Volunteer group process facilitators are also scheduled to work in partnership with the clinical staff.

Comp-Care Incorporated, American Medical Internation, National Medical Enterprises and Beverly Enterprises will provide the initial evaulatuon of the New York Clinic's operation and sufficient analysis in order that it be properly replicated. They will also provide an evaluation model plus the necessary collection and evaluation of the data to determine medical/social program effectiveness.

The Attorney General's Office will provide crime and criminal statistics for the evaluation of teh effectiveness of the program in crime reduction or prevention.

The Los Angeles Police Department will provide liaison with the community in the skid row areas and liaison with the Weingart Center and Volunteers of America. Volunteers will provide expertise in the other areas as required. The Los Angeles Sheriff's Department will provide liaison with the community in surrounding areas.

Preliminary Conclusions

Research data from the model program in New York City show the low costs and high effectiveness of this type of treatment with difficult clients. Therefore, concurrent with the initiation of that program will be the examination of the use of this type of treatment at the Los Angeles

County Jail and at other decentralized locations. Foundation and/or social agency funding will be sought along with grants from a second phase of this project which will expand on the medical model with self-help groups and labor entrepreneurship.

MISSION STATEMENT

OUR MISSION IS TO MAKE POSSIBLE FREEDOM FROM SUBSTANCE ABUSE AND CRIMINAL ACTIVITY BY PROVIDING SOCIAL AND ECONOMIC REBIRTH AS THE MOTIVATION AND GOAL OF RECOVERY.

To offenders, our goal is to provide healing, linking and opportunities for a stake in lifestyles that break with the past.

To social agencies, our goal is to relieve overburdened staff and resources by providing innovative recovery and growth programs within the realities of these times.

To criminal justice and law enforcement, our goal is to provide a bridge to the rehabilitation of criminals and disadvantaged persons, and to assist the system in improving both its servies and the public perception of its concern for protecting community life.

To the community, our goal is to return rehabilitated citizens qualified to do productive work valued by the the community.

For us all, our goal is to provide caring and community building, dedicated to liberating the family of man from the unworkability of the past.

STEERING COMMITTEE GUIDELINES

- Serve the spirit and conscience of Los Angeles
- Become an outstanding example of a public/private partnership
- Achieve the highest qualities of individual and group creativity
- Expand the fellowship of group synergy
- Serve as role models for citizenship and community
- Strive for simplicity
- Maximize the future

CPTSAT August 1, 1986
B.M.

CHAMBERS OF
The Municipal Court
BEVERLY HILLS JUDICIAL DISTRICT
9355 BURTON WAY
BEVERLY HILLS, CALIFORNIA 90210
CHARLES G. RUBIN, JUDGE

April 16, 1986

Mayor Tom Bradley
Los Angeles City Hall
200 N. Spring Street
Los Angeles, California 90012

Re: Crime Prevention Through Substance Abuse Treatment project.

Dear Mayor Bradley:

As a former Los Angeles County Deputy District Attorney and private trial attorney for sixteen years, and presently a Municipal Court Judge for over three years, I have become very involved in the identification and treatment of substance (alcohol and drug) abusers. In my opinion, the vast majority of persons who commit crimes are substance abusers. It is urgent that this problem be addressed at the community level.

I am involved with the South Central Organizing Community (SCOC) and United Neighborhood Organization (UNO), which, as you know, are confronting this problem from a prevention and law enforcement approach.

There is another organization with which I have become involved, called Crime Prevention Through Substance Abuse Treatment (CPTSAT). This project is modeled after the Lincoln Project in the Bronx, New York, which has successfully treated and rehabilitated substance abusers and returned them into the community as productive citizens. The project is self-supporting.

Many members of the Los Angeles County Sheriff's Department and Los Angeles Police Department, as well as a number of other concerned community organizations and persons have formed CPTSAT in order to establish a Lincoln Project type program in Los Angeles. Through the hard work of well-over one hundred volunteers the program is all set to begin treating and training substance abusers in the Central City area where it is most needed. A City facility at 526 So. San Pedro Street is being considered for rental at a nominal rate.

It is believed that the program will take many of the presently incapacitated street dwellers in the area and rehabilitate them on an out-patient basis, so they may return to their homes and/or jobs of origin. This will substantially reduce the problem population that presently blights that business and residential neighborhood. The program is privately funded. If successful, the CPTSAT program will be expanded to other areas of the City and County of Los Angeles.

I am writing you because I have been informed that you are appointing a Citizen Task Force on Central City East, and will be having a news conference to announce it.

In deference to your plans, we have been delaying a meeting with Councilman Gilbert Lindsay and members of the Central City East Association to obtain their approval of the CPTSAT project.

On behalf of the many volunteers who are ready to begin the CPTSAT project, may I respectfully request that your Citizen Task Force be implemented and announced at the earliest possible time, so we may continue in our efforts to obtain the blessings of the local businesspersons and Councilman Lindsay. The matter can then be presented to the Los Angeles City Council for its approval of the lease of the 526 So. San Pedro Street premises to CPTSAT.

The CPTSAT project is one of the most promising and exciting concepts to address the problem of substance abuse in our city and county in many years.

If you have any questions concerning this matter, please do not hesitate to contact me.

Sincerely,

Charles G. Rubin
Assistant Presiding Judge

cc: Councilman Gilbert W. Lindsay, (9th District)

cc: Bruce Monroe, Director Volunteer Initiatives,
Los Angeles County Sheriff's Department ✓

REPLY TO
SACRAMENTO ADDRESS
ROOM 2000 STATE CAPITOL
SACRAMENTO CA 95814
TELEPHONE (916) 445-3490

DISTRICT ADDRESS
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ROS MORALES
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CALIFORNIA LEGISLATURE

Senate

ART TORRES
SENATOR TWENTY-FOURTH DISTRICT
LOS ANGELES COUNTY
CHAIRMAN
TOXICS AND PUBLIC SAFETY MANAGEMENT

CONSTITUTIONAL AMENDMENTS
EDUCATION
JUDICIARY
PUBLIC EMPLOYMENT AND RETIREMENT
TRANSPORTATION
JOINT COMMITTEE ON PUBLIC PENSION FUND INVESTMENTS
JOINT COMMITTEE FOR THE REVIEW OF THE MASTER PLAN FOR HIGHER EDUCATION
JOINT COMMITTEE ON SCIENCE AND TECHNOLOGY
SELECT COMMITTEE ON BUSINESS DEVELOPMENT
SELECT COMMITTEE ON TOURISM AND AVIATION (CHAIRMAN)
SUBCOMMITTEE ON VICTIMS' RIGHTS

November 21, 1986

Mr. Bruce Monroe, President
Turnaround Alternative Treatment Center
526 S. San Pedro
Los Angeles, CA 90013

Dear Mr. Monroe:

It is my pleasure to send my congratulations and best wishes to you and the Turnaround Center as your doors open to serve our community.

Drug abuse is one of the gravest problems facing California. Our future depends on our ability to reduce the epidemic of substance abuse and addiction which destroys lives, families and communities.

Towards that end, I believe that innovative programs like Turnaround are some of the soundest investments we can make for our community. The war on drugs must begin not in far away countries, but on our own streets and playgrounds. We must strive to comprehend the reasons for substance abuse, and then act to stem the epidemic.

Again, my congratulations and best wishes for success at Turnaround. You have my support and appreciation for advancing efforts to make Los Angeles drug free, and a healthier place for all to live.

Sincerely,

ART TORRES
Senator

DANIEL E. LUNGREN
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Congress of the United States
House of Representatives
Washington, DC 20515

[illegible]

[illegible]

[illegible]

[illegible]

August 26, 1986

Mr. Bruce Monroe President CPTSAT Inc
169 Pier Ave.
Santa Monica, CA 90405

Dear Mr. Monroe:

Thank you for your letter concerning the NIJ. I appreciate the benefit of your thoughts.

I applaud you efforts to decrease the crime rate through treatment of hard-core criminals and substance abusers. There is a significant body of research which supports the thesis that an inordinate amount of crime in the United States is committed by substance abusers. While I do not have first hand knowledge of the specific parameters of your proposal, from what you have sent me it appears to be most interesting.

Normally, it is not my practice to promote specific candidates for grants, because I feel they should be accepted on the basis of their merit. Nevertheless, I would be happy to make my staff available to you if you have any additional information that you feel valuable for us, or if you have any questions about the grant application process.

Sincerely,

Daniel E. Lungren
Member of Congress

DEL/dvm

Drug addicts, acupuncture, and retraining

Acupuncture has been used by treatment workers to help drug addicts for approximately 15 years. The Journal first published a report on the procedure (see clippings below) in March, 1976.

Today, clinics in Great Britain and Hungary, as well as across the United States, consider acupuncture a regular treatment modality.

And, one clinic in Los Angeles has added an economic alternative: a model to fit use of acupuncture, with support groups, in a drop-in, detoxification setting, hoping to reduce crime in the downtown area. Correspondent Connie Tweig reports.

LOS ANGELES — A drop-in, detoxification centre in the downtown skid row area here is treating both drug addicts and those addicted to nicotine and caffeine through acupuncture.

The Turnaround Alternative Treatment Center, a non-profit affiliate of the Crime Prevention Through Substance Abuse Treatment organization, was started by volunteers from the sheriff's department, the Los Angeles Police Department (LAPD), downtown social agencies, the medical community, and the business community — diverse groups with a single focus: reducing urban crime by reducing drug abuse.

At the clinic's official opening in January, Los Angeles County Supervisor Edmund Edelman said: "We estimate 50% of all crimes are committed by drug-addicted people. If this program works, we could duplicate it throughout the county."

Retired LAPD captain Diane Harbor spearheaded the project for precisely the same reason: "A high percentage of crime is committed by people seeking money to buy drugs. If we can stem this tide, we should begin to see a big reduction in crime, and all of its economic conse-

with lifestyle intervention and commitment by the patient.

"I've had excellent results using acupuncture to reduce cigarette smoking, for instance. But, nothing can work unless the patient really wants it."

Basil Clymon, MD, associate chief of staff for ambulatory care at the Veteran's Administration Hospital in Sepulveda, was formerly in charge of a detoxification service for Los Angeles County and University of Southern California.

"It's important not to lose sight of potential medical complications that can come with drug addiction and withdrawal.

"If the stress of withdrawal is added to medical problems like ulcers, trauma, or infection, it can exacerbate the problem and make patients more ill," he said.

"Those who use alternative techniques tend to get over-focused on their own treatment modalities and overlook other problems. Acupuncture can't do no harm, provided it's done with medical observation."

The Turnaround treatment consists of placing five needles in specific sites in each ear of the patient, every day for about two weeks (The Journal, May, 1983).

Gary Archer, an acupuncturist at SAMHA, explains: "In Chinese medicine, the ear is a microcosm of the whole body, so we can treat any organ by treating the ear.

"Drugs deplete the body's energy, but acupuncture helps clients maintain their energy. It eases the whole process so they can cope with the anxiety and other physical problems during drug withdrawal."

Self-support

Steve Wolf, a psychotherapist in private practice in West Los Angeles, is training counsellors to organize mutual, self-support groups for those trying to kick their habits.

"We realize that we're attempting the impossible," he said.

...member ... Turnaround's steering committee, concurs: "The courts are backed up with criminal cases in which drugs and alcohol play a significant role."

Ms Harber said she was frustrated with the revolving door of arresting drug users and sending them back out on the streets.

"And, I hadn't seen a treatment program in existence that had had a great deal of success with hard-core addicts."

Then she learned about a New York city treatment centre using acupuncture to treat addiction (The Journal, January 1981); she went to see how it worked. Pioneered by psychiatrist Michael Smith, PhD, at Lincoln Hospital in the South Bronx, the program has achieved good results for 13 years with hard-core addicts.

Counselling too

"We were using methadone to treat heroin addicts when we read reports of a doctor in Hong Kong using acupuncture," Dr Smith told The Journal.

At first, Dr Smith used acupuncture in conjunction with counselling for 20-year alcoholics referred by the Welfare Department. A survey showed 20% of them had stopped drinking.

The acupuncture program was then used, in combination with Alcoholics Anonymous and Narcotics Anonymous, to treat cocaine and heroin addicts. The result: a 40% to 50% success rate.

"Acupuncture alone is not sufficient," Dr Smith reports. "It depends on a combination of treatments. But in the first month, it works far better than any other mode of outpatient treatment that exists.

"If people are to stay clean for years, they need to look at their lifestyles on an ongoing basis."

THE BACK PAGE

Today, clinics in Boston, Massachusetts; Washington, DC; Albuquerque, New Mexico; Minneapolis, Minnesota; San Francisco, California; Portland, Oregon; two United States Native reservations, Great Britain, and Hungary use Dr Smith's centre as a model.

To launch Turnaround here, Ms Harber recruited Bruce Monroe, a sheriff's department planner, who volunteers as the project's steering committee chairman and director. Mr Monroe found backing through a small grant from the California Community Foundation and thousands of dollars in goods and services from local businesses. The city donated the site on San Pedro Street.

Mr Monroe designed a three-tiered program: acupuncture, support groups, and economic alternatives.

Mr Monroe: "This is the first program in Los Angeles County to address alcohol and drug problems in the context of medical, social, and economic development, which are all necessary for successful, permanent recovery."

Turnaround's pilot program has been underway at the SAMRA School of Acupuncture in the Westlake District for three months. A satellite clinic treats addictions free of charge from 7 am to 10 am Monday through Saturday, while the San Pedro centre charges on a sliding scale. Turnaround also has a Los Angeles hotline, 623-HELP.

Turnaround's staff has treated several hundred patients, including Albert, 38, who had a $400-per-day heroin habit for eight years before he began treatments at Turnaround: "I went in pretty sick, but decided to go cold turkey after the first treatment. Now, the cravings are down, and I can think straight and sleep okay. Before, all I could think of was a fix."

Audrey McCoy, 38, a writer living in the Westlake District, is also a graduate of the program. He had smoked cigarettes since he was 10 years old and, until recently, hadn't gone without one for 24 hours. Today, he's a non-smoker and proud of it.

"If I had known it was so easy, I would have done it sooner," he said.

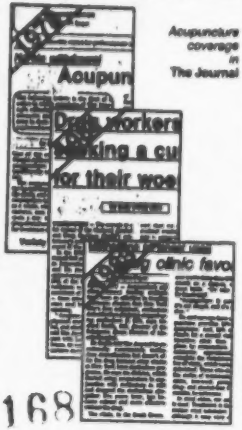
David Katzin, MD, of Los Angeles, a member of Turnaround's medical advisory board, is enthusiastic: "The early results are extremely encouraging and indicate acupuncture is an effective, non-toxic alternative to the use of methadone and other pharmacologic approaches to detoxification."

However, several outside experts point to possible shortcomings. P. Joseph Frawley, MD, chief of staff at Schick Shadel Hospital, Santa Barbara, California, where a combination of medical and behavioral approaches is used to treat addiction, questions long-term effectiveness.

"I've seen reports of acupuncture helping withdrawal," Dr Frawley said. "But, I haven't seen reports of any long-term recovery rates."

Larry Eckstein, MD, of Santa Monica, who uses acupuncture as part of his practice, said: "Long-term recovery must be based on multi-level interventions.

"Acupuncture needs to be supplemented



Acupuncture coverage in The Journal

"These people have ...4-hour-a-day habit, and they come he... r one hour that's different. In standard treatment, they would be locked away from their normal lives, cut off from external contact, to break their patterns. But, even those programs have only a 30% to 40% success rate."

Mr Wolf designed a social support system to help people deal with the emotional issues that come up during withdrawal.

"Clients learn to recognise their early warning signs that precede the desire for a substance. They learn to make an internal connection by using their own breath to ease the craving. And, they can break their patterns of social isolation by creating friendships with others who take personal responsibility for their addictions.

"Acupuncturists say every symptom is an imbalance of the whole system.

"We see people's addictions as symptoms of their social environment. They need to develop new identities, new life plans, and that is the aim of the self-support groups."

Besides crisis intervention, counsellors refer clients to other community agencies and resources here.

"We don't want to duplicate other services already available," Mr Wolf said.

Successful graduates of the program are expected to try new business ventures.

"We're planning to set up a pipeline of activities through which people can pass back into society," explained Buddy Nadler, chairman of the business committee.

"Projects begin simply and in a variety of forms." For example, a local janitorial service offers training and jobs, and a community beautification project includes instruction in carpentry and other building skills.

Mr Nadler: "The key idea is labor entrepreneurs, people who will develop businesses and become part-owners in them. These enterprises will be rooted in the relationships that are built in the self-help groups."

"We know that acupuncture can detox them," Mr Wolf said. "But they are only declared clean by most experts after 18 months.

"So acupuncture is only the first step. That's why we're designing more into the program — an effort at real transformation, real healing."

Los Angeles Times
VIEW
Friday, November 28, 1986 / Part V-A

Doctors Use Acupuncture to Help Addicts Kick Habit

By CONNIE ZWEIG

Even the most successful substance abuse programs claim success rates of only 30% to 40%. As a result, some Los Angeles residents suffering from addictions are trying a new tack: They're fighting needles with needles.

Both hard-drug addictions and nicotine and caffeine addiction are being treated with the ancient Chinese healing art of acupuncture at the Turnaround Alternative Treatment Center on Skid Row. The nonprofit drop-in center was started by volunteers from the Los Angeles sheriff's and police departments, downtown social agencies and the medical and business communities.

Effort to Lower Crime

The cooperative effort, say organizers, has a single focus: to reduce urban crime by reducing drug abuse.

"We estimate that 90% of all crimes are committed by drug-addicted people," Los Angeles County Supervisor Edmund Edelman said at the center's official opening. "If this program works, we could duplicate it throughout the county." Also attending the recent opening were representatives of Mayor Tom Bradley, the LAPD and the sheriff's department.

Capt. Diane Harber (ret.), former head of the LAPD's West Valley Patrol Division and a driving force behind Turnaround, said she was frustrated by the revolving-door process of arresting drug users and seeing them sent back out on the streets. "And I hadn't seen a treatment program in existence that had had a great deal of success with hard-core addicts."

After hearing about a New York City center that claimed to have good results treating hard-core addicts with acupuncture, Harber went to see how it worked.

"We were using methadone to treat heroin addicts when we read reports of a doctor in Hong Kong using acupuncture for addiction," said Dr. Michael Smith, a psychiatrist who began the New York program 13 years ago at Lincoln Medical and Mental Health Center in the South Bronx. "So we decided to try it here."

"Acupuncture alone is not sufficient," Smith reported. "It [ending addiction] depends on a combination of treatments. But in the first months it works far better than any other mode of outpatient treatment that exists.

"If people are to stay clean for years," Smith said, "they need to look at their life styles on an ongoing basis."

Clinics in Boston, Washington, Albuquerque, Minneapolis, San Francisco, Portland, two Indian reservations, England and Hungary have modeled their programs on the South Bronx center.

Long-Term Recovery Rates

Asked about the value of acupuncture in treating addiction, some physicians expressed reservations. For example, Dr. P. Joseph Frawley, chief of staff at Schick Shadel Hospital in Santa Barbara, which uses a combination of medical and behavioral approaches to treat addiction, said, "I've seen reports of acupuncture helping withdrawal, but I haven't seen reports of any long-term recovery rates."

And Dr. Basil Clyman, associate chief of staff for ambulatory care at the Veterans Administration Hospital at Wilshire and Sawtelle boulevards and former head of a joint detoxification service for Los Angeles County and the University of Southern California said, "It's important not to lose sight of potential medical complications that can come with drug addiction and withdrawal.

"If the stress of withdrawal is added to medical problems like ulcers, trauma or infection, it can exacerbate the problem and make patients more ill," Clyman said.

Those who use alternative techniques tend to get over-focused on their own treatment modalities and overlook other problems. Acupuncture can do no harm, provided it's done with medical observation."

Los Angeles physician David Katain, a member of Turnaround's medical advisory board, said early results of the program are "extremely encouraging and indicate acupuncture is an effective, nontoxic alternative to the use of methadone and other pharmacologic approaches to de-tumification."

Bruce Monroe, a long-range planner with the sheriff's department, was recruited to launch Turnaround and serves as director and chairman of the steering committee. A small grant was obtained from the California Community Foundation as were thousands of dollars in goods and services from local businesses. Monroe also was instrumental in leasing the San Pedro Street site from the city free of charge.

Three-Tiered Program

Monroe and the planning committee designed a three-tiered program: acupuncture, support groups, economic alternatives.

Turnaround's pilot program has been under way at the SAMRA University of Oriental Medicine in the Westlake District for three months. The satellite clinic has been open to treat addicts free of charge from 7 a.m. to 10 a.m., Monday through Saturday; the center on San Pedro will charge on a sliding scale. The Turnaround hot line is (213) 623-HELP.

During its first two weeks, Turnaround personnel treated about 180 patients. Seventy percent returned for repeat treatments, according to Monroe.

Treatment consists of placing five needles in specific sites in each ear of the patient every day for about two weeks, said Gary Archer, an acupuncturist at SAMRA. "In Chinese medicine, the ear is a microcosm of the whole body, so we can treat any organ by treating the ear."

Steve Wolf, a psychotherapist in private practice in West Los Angeles, is training counselors to run support groups for those trying to kick their habits.

Not Standard Treatment

"We realize that we're attempting the impossible," Wolf said. "These people have a 24-hour-a-day habit, and they come here for one hour that's different. In the standard treatment, they would be locked away from their normal lives, cut off from external contact in order to break their patterns."

Wolf said a social support system has been designed to help people with the emotional issues that come up during withdrawal. "Clients learn to recognize their bodies' early warning signs that precede the desire for a substance. They learn to make an internal connection by using their own breath to ease the craving. And they [learn that they] can break their patterns of social isolation by creating friendships with others who take personal responsibility for their addictions."

Job training and possible employment awaits those who move successfully through the program. A local janitorial service offers training and jobs, and a community beautification project includes instruction in carpentry and other building skills.

ADDICTS: At Turnaround, Acupuncture Helps

RICK MEYER / Los Angeles Times

Acupuncture's an alternative at the Turnaround Center.

L.A. County Supervisor Edmund Edelman spoke at opening of center on Skid Row.

RICK MEYER / Los Angeles Times

Carol Taub, the clinical director of Turnaround Alternative Treatment Center, places acupuncture needles in a client's ear.

Treating the dope
habit with acupuncture.

Although it sounds like some new miracle treatment, the Oriental practice of acupuncture hasn't changed in the 2,000 years of its existence. The insertion of hair-thin needles into calculated parts of the body has been used to treat a variety of ailments, such as arthritis pain, impotence, obesity, and insomnia.

And today it is astounding Western observers with its success rate in treating heroin and crack addiction. Having celebrities like Boy George, Keith Richards, and Eric Clapton endorse it has only enhanced acupuncture's cachet.

But don't think this is just some kind of jet-set cure. "We've been doing acupuncture here for 13 years to alleviate acute heroin withdrawal."

CHANGING TRACKS

BY JENNIFER LANDEY PHOTOGRAPHS BY PETER MARLOW

116 PENTHOUSE • MARCH, 1987

"Acupuncture neutralizes
the craving for heroin. It eliminates
the cold-turkey factor."

says Dr. Michael Smith, medical director of the Lincoln Hospital Acupuncture Clinic in one of the poorest parts of New York City. It was the first clinic in the U.S. to use the treatment. Clinics in Washington, D.C., Chicago, Boston, New Mexico, and many more now exist.

How does acupuncture really work? Dacajeweish, who practices at Green Cross, Inc., in Washington, D.C., says that "in humans there are natural body opiates produced by the brain called endorphins. When acupuncture needles are inserted into various meridian points, the prickling sensation tells the brain it's under attack and the brain secretes endorphins that act as natural opiates and painkillers."

In treating heroin addicts, the acupuncturist focuses on two main points in the ears. "There's a slight pain when the needles are inserted," says Dr. J. N. Wu, president of Green Cross, Inc. "The needle stays in on an average of 20 to 30 minutes," Wu adds. "It's a calming agent."

Acupuncture is cost-efficient, has no known side effects, and requires no prescribing of drugs to kick a drug habit. "People are just beginning to know about it on a national level," says Dacajeweish. "Acupuncture neutralizes the craving for drugs; it eliminates the cold-turkey factor."

Although former Who star Pete Townshend says, "If I hadn't gotten help from acupuncture, I'd be dead," doctors stress that no treatment alone offers guarantees. Nonetheless, it appears that this ancient technique may be today's best hope of treating the heroin plague.

'Latest Cure' Brings Media Attention, Hope

Turnaround Center Uses Acupuncture, Herbs to Help Drug Addicts

by Tom Chorneau

The Turnaround Center, Skid Row's newest social service provider—where acupuncture and Chinese herbal medicine treat substance abusers—is also Skid Row's brightest new media star.

Beginning several weeks ago, with stories placed in a pair of Westside weeklies, the coverage of the center's opening has been enough to turn the city's press agents green, blue, and red with envy.

National Public Radio was here a week or two ago, and put together a feature this novel program modeled after a similar one established several years ago at New York's Lincoln Hospital. Before that broadcast, the *Times View* ran its piece, as did the *Herald*, followed closely by a feature in *La Opinion*. There's also been TV coverage—Channel 7 and Channel 11, and at least one of the news-radio stations has given recent airtime.

And the blitz isn't over yet. On a recent Tuesday morning, a crew is down from Channel 13 News doing a spot; yet another *Times* reporter is hanging around; and, of course, the *Downtown News*.

"We're trying to get all of this [press disruption] done at one time," says Bob Morris, the youthful administrator of Turnaround. "The treatment room has got to be kept as quiet and as tranquil as possible, because relaxation is extremely important. The patients you see in there now are meditating, concentrating on breathing techniques, even praying.

"It's very important that we're not going through all these interruptions every day," says Morris.

That might be a lot harder than it seems. Despite having already entertained virtually every viable L.A. news group, Turnaround Center has the guaranteed allure of a new treatment for one of America's great problems.

Morris claims that the success rates for the original program in New York City far outshine traditional approaches.

He says that at most inpatient clinics, only about 25 percent of the addicts effectively remain clean. The New York program, now 11 years old, boasts that 60 percent of its patients who complete the first two-week period, remain drug-free six months later; 40 percent are still straight after two years.

Data on successful patients after two years is hard to come by, partly, says Morris, because they *are* successful and back in mainstream society.

"We can't solve anyone's substance problem by locking them in a room for a couple weeks," Morris says. "We call that 'pajama' medication. The problem with that approach is that someday you've got to unlock that door and let the patient out."

Turnaround Center is designed as a 'drop-in' service, where daily treatments and ongoing group therapy are recommended, but where the demand for staying clean comes from the individual.

They are also quick to point out that, unlike a substance 'substitution' program like methadone treatment, this program offers 'drug-free' detoxification.

How effective is acupuncture in solving the problems of drug and alcohol addiction?

"From what we've been able to document thus far, it's extremely effective in dealing with the problems of withdrawal," explains Dr. John Clark, Chief Physician at the L.A. County Sheriff's Department/ Medical Services, and Vice Chairman of the Turnaround Center's Board of Directors.

He says that acupuncture seems to help the patient cope with the physical and emotional effects of detox—things like anxiety, emotional instability, digestive problems and the inability to eat and sleep. They believe this method helps the body recover faster and allows other forms of treatment—social, economic, emotional—to have a greater impact, and sooner.

So great are his expectations for this program that

Bob Morris.

Clark is looking into the possibility of a pilot acupuncture detox within the County Jail setting.

"The County Sheriff's are not in the business of dispensing methadone," Dr. Clark says. "But at the same time, we do see anywhere from 200 to 300 inmates a month, suffering acute withdrawal, who require some level of medical supervison."

These cases appear among the nearly 7,500 monthly drug-related arrests made by the Sheriff's Department.

Clark says that sometime within the next three months he will be trying to work out the details for funding and staff. No more than 20 inmates would be brought into the pilot, but after a year or so, Clark hopes for a wider program.

Tyron, age 30, has been addicted to cocaine and alcohol "for some time now." He has been in the Turnaround program for three weeks, and says he finds himself "hanging around the Center more and more, because of the support here."

He said that he'd been through detox over at the Weingart Center, and once at the Union Mission. But, because he was still unemployed and living off the County dole, he had to return each time to life on Skid Row—which brought him back to drug use.

"I heard about this place opening," he says. "The Chinese stuff? People said it might help. I don't know, I guess I came because I'd tried everything else—why not this?

"I stayed with it, but at first I didn't really feel any better. I still had cravings. But now, I'm feeling much stronger. I sleep better, and just feel good.

"I don't know if I'm always going to be able to stay clean, I still think sometimes about (crack use) and still see some of my friends still using. But, at least now I got hope."

Acupuncture demonstration with needles placed into ears of subject.

TURNAROUND
Alternative Treatment Center

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Bruce Monroe

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Steve Wall

Chief Financial Officer
Joel Edelman

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Robert J. Martin, Captain
L.A. Police Dept.

Buddy Muller

Clare L. Seldon

Michael O. Smith, M.D.
Lincoln Hospital, N.Y.

Marion Williamson
Chair L Development Board

Steve Wall, Ph.D.

Caroline C. Vincent, J.D.
Attorney at Law and Mediator,
Corporate Counsel

Organizations listed for identification purposes only

More than ever, homelessness, urban neglect, unemployment and crime are growing in segments of the Los Angeles basin. Legitimate businesses, especially in the downtown area, are now plagued by constant theft, as well the ever-present threat of harassment and physical danger to employees and customers -- many of whom are understandably reluctant to work in and/or patronize local businesses.

It is acknowledged by law enforcement experts that as much as 90% of urban crime is drug or alcohol related. This may take the form of crimes committed to support a habit, crimes committed under the influence, or crimes resulting from the illegal distribution of drugs. Substance abuse is our most urgent social problem.

Clearly, credit must go to the existing downtown social agencies and support services that have been making strides in the treatment and socialization of substance abusers. However, attempts to tackle this monumental social problem have been fragmented at best, and we believe a more comprehensive approach is much needed and long overdue.

The TURNAROUND Alternative Treatment Center in downtown Los Angeles offers a total program for the alleviation of chronic substance abuse: detoxification and sobriety maintenance through the use of low-cost medical acupuncture, resocialization programs and economic recovery. Substance abuse services are offered to everyone -- regardless of race, color or ability to pay -- at our treatment centers in the MacArthur Park area, and our new center on San Pedro street. To accomplish this, we need your support. We are urgently in need of funds to continue substance abuse treatment for the homeless and transient population.

TURNAROUND, which is an affiliate of CPTSAT, Inc. (Crime Prevention Through Substance Abuse Treatment), is a non-profit organization with IRS 501.C.3 status founded by volunteers from the Los Angeles Sheriff's Department, the Los Angeles Police Department, downtown social agencies, the medical community and businesses throughout the Los Angeles basin. The treatment center is modeled after a more than 10-year-old program based at Lincoln Hospital in the Bronx, which has treated hardcore substance abusers in this Black and Latin "ghetto" with great success.

Funds to continue the successful treatment of substance abusers in our Los Angeles program are running dangerously low. Won't you join our list of contributors who are supporting the alleviation of substance abuse and crime in Los Angeles, not only for your company and its employees, but for the regeneration of the community as well?

526 S. San Pedro, Los Angeles, CA 90013 (213) 623-HELP
An affiliate of CPTSAT Inc. A non-profit, public benefit corporation

TURNAROUND
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Brad Sherman

Secretary

Chief Financial Officer

Founding Director
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Mark Thomas
L.A. County Board's

Vice Chairperson
L.A. County Board's

Prof Sciences, J.D.C.L.
Attorney at Law & Educator

Dr Morris, M.A.
M.F.C.C., C.C.D.

Robert J. Morris, Captain
L.A. Police Dept.

Bobby Muller

Clare L. Ortner

Richard D. Smith, M.D.
Cedars Hospital, D.C.

Business Philanthropic
Affairs, Development Board

Dave Wall, Ph.D.

Jonathan C. Trevor, J.D.
Attorney at Law and Educator
Corporate Counsel

Organizations listed for
identification purposes only

VOLUNTEERS NEEDED

A TWO YEAR PROGRAM THAT PROVIDES DRUG-FREE DETOX AND RECOVERY TREATMENT

We need assistance on all levels:

1. Intake - conduct preliminary interview;
2. Acupuncture ear points - place needles in ear points*;
3. Relaxation techniques - conduct movement classes;
4. Movement exercises - conduct movement classes;
5. Contact persons - organize referrals and serve as an advocate for recovering patients;
6. Group facilitators (Eg. A.A., N.A.) - facilitates self-help groups;
7. Nutrition - prescribe and administer nutritional supplements;
8. Teach job training and economic development
9. Fund raising - recruit volunteers and raise funds;
10. Administration - administer programs via communication and coordination;
11. Maintain and remodel building;
12. Outreach - negotiate referrals to and from social service agencies;

If you have knowledge of the above, are willing to learn and assist, we welcome you. Please contact:

TURNAROUND

(213) 623-HELP

Samantha Marshall
Bob Morris

* Approval for this position is necessary. Please indicate if you wish to become Certified.

526 S. San Pedro, Los Angeles, CA 90013 (213) 623-HELP
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Michael G. Smith, M.D.
Lanterman Hospital, D.T.

Hanover Williamson
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Candace C. Vincent, J.D.
Attorney at Law and Mediator
Carpenter Company

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identification purposes only.

March 31, 1987

The Honorable Augustus F. Hawkins, Chairman
U.S. House of Representatives
Committee on Education and Labor
4509 So. Broadway
Los Angeles, CA 90037

Dear Congressman Hawkins:

At your request, we are forwarding a white paper proposing a community action demonstration project as a partial solution to bringing affordable housing to the homeless. What we propose is best read in the context of our testimony at your hearing on Friday, March 20, 1987 in Panel 3.

We recognize that more planning must go into our project before it would be eligible for funding but do not want to overinvest in detailed planning until we have a positive reaction from you and/or your staff.

Respectfully,

Bruce Monroe

Bruce Monroe, President CPTSAT, Inc.

cc: Representatives E.R. Roybal & Matthew Martinez

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March 25, 1987

To: CPTSAT, Inc.
From: Economic Development Committee, Buddy Nadler, Chair
Subject: A Proposal For A Demonstration Grant To Seed A Land Trust To Provide Homeless People With Residences

Part of the permanent recovery process - the third and final phase prior to socio-economic re-entry into the larger society - is designed as a "pipeline" of temporary residences through which recovering substance abusers can move while refining their social and economic skills. While one or more of these habitats should be in the downtown area, most of them will be in suburban areas with good business opportunity environments. The pipeline begins with drug free detoxification as the first step, socialization soon after, with a housing and/or residential program for each of the small businesses being inculcated. We do this in order to regulate and administer the recovery contracts agreed upon between TURNAROUND (i.e. the program) and the individual and his group. This housing arrangement has three functions:

1- To facilitate recovery and treatment plan success and contracts entered into during the initial contact with the TURNAROUND self-help groups program.

2- To deepen bonding relationships among the residents: from patients, to "buddies", to groups, to teams, to work partners, to stakeholders in business cooperatives.

3- To create both temporary and permanent housing habitats rebuilt largely with "sweat equity." This housing serves initially as a quasi-monastic dormitory fellowship and afterwards as a neighborhood center from which activities fan out, and through which economic security is created.

526 S. San Pedro, Los Angeles, CA 90013 (213) 623-HELP
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We need skilled planners, professional architects, contractors and real estate builder-developers to teach inhabitants sweat-equity skills and guide our building restorations and/or original structures. Building trade skills are demanding activities for many abusers but teachable, too. This allows positive work experiences to emerge as a result that satisfies and serves the life style of the "builders" in a personal way. As these participants work, clean up, reach goals and resocialise - under gradually diminishing supervision - they may choose to be involved in preparing new residences for themselves and other homeless people. If participant groups (i.e. residents, inhabitants, groups) choose, and are ready to upgrade their housing situation, the newly-vacated rooms become the site of pipeline entry for new participant groups. In this way, we seek to establish traditions, continuity and alcohol/drug free environments for new groups who enter the TURNAROUND path of permanent recovery and economic self-sufficiency.

While the land on which the properties are located will be held in a land trust for future generations, the buildings will be regularly refurbished. Each residence, be it refurbished homes, hotel spaces, apartments, dormitories or lofts, old or new, will be developed with its own unique style and energy. Constant, unending personal and residential upgrading will be part of the live-in contract for program group participants. Subsequent participants will bear witness to the program's workability while experiencing the handiwork and living traditions of prior abusers who have passed through the spaces. Group achievements will be valued over personal ones. The success of each residence is a proud, fraternal way for groups to interface with the society they have chosen to re-enter, while still retaining roots in the protected environments that nurture them. Each residence is intended to to become a conscious fellowship as well as an intentional, cooperative community. While some groups will become bonded to certain residences, it is essential they keep moving through the pipeline to demonstrate that group success is more important than personal preferences. A "best case" scenario would be a chain of residences, rebuilt and inhabited by former substance abusers, in which new recoverers can move through progressive stages of recovery before becoming stakeholders in successful cooperative small businesses.

One of our priority businesses is small apartment building renovation. Another business will be contracted maintenance and property management of non-CPTSAT buildings: a rental, custodial and building maintenance service. In each of the residences, ideally, conference and training rooms - as well as recreational spaces - will be developed for discussing and planning new businesses, and bringing new ideas to life.

Seed money is necessary to launch this demonstration project. I propose we seek Federal funds as this project has implications as a national model.

At our next Director's meeting, I will ask formal approval to lobby for Federal demonstration seed money.

Please contact me if you have specific suggestions about moving ahead. Carlos Rocha and I have begun a search for potential properties and tax-lien auction properties. Please let us know of any you hear of. Thanks.

STATEMENT OF BUDDY NADLER, CHAIRMAN, ECONOMIC DEVELOPMENT COMMITTEE

Mr. NADLER. Good afternoon.

Some of us active in the skid row area have a vision of a transformed Los Angeles Basin, particularly the inner city with less crime, adequate shelter, greater prosperity, happy families and empty jails.

Our vision stated in our mission statement is as follows. The mission of turnaround is to develop productive recovering addicts and groups of recovering addicts rooted in health, personal growth and business sense to compete successfully in the free market as small business partners.

Our objective is to provide the tools and means by which groups of people work for themselves and work in harmony with others. As a result former substance abusers become productive business partners and the urban swamps begin to disappear.

We believe that our program here in Los Angeles could become a national model for a partial solution to the need for full employment for the homeless. Standing in the way of the accomplishment of this dream are misunderstandings, fear, frustration, desperation, bigotry, bias, bureacracy, complacency, out of date concepts, and a lack of congressional and executive leadership. One such out of date concept is the concept of jobs, and job training. Jobs for the homeless never have been and never will be a permanent solution.

A more enlightened concept is the concept of labor entreprenuership creating jobs from which they can never be fired, and in which they will labor, strive and work twice as hard on behalf of their own self interests than they ever would to satisfy an employer's demands.

Groups working shoulder to shoulder for an insured future in which they have personal pride of accomplishment and are a vastly superior alternative to another CETA or JTPA program. Our program is dealing with these roadblocks in a new program on skid row called the Turnaround Alternative Treatment Center.

This outpatient detox clinic coupled with the self help group program is beginning the process of incubating small businesses and worker owned cooperatives in the tradition of AMANA, United Parcel Service, and People's Express. Delancy Street too, but they are residential.

What we propose will not necessarily work for all the homeless, but for those groups who are most highly motivated, encouragement, guidance and resources such as we provide will reduce the problem. For the less motivated, Delancy Street type programs should be second in priority.

Perhaps a minority of the homeless may require sheltering in sheltered workshop jobs. But we argue against the dependence created by this type of alternative. We argue very strongly that dealing with each homeless person as an individual and attending only to their short term needs has only perpetuated the problem.

Organizing groups and nuturing groups to help themselves, to help one another in the struggle for collective long-term success is a more potentially successful solution and would be more cost effective since it is a one time investment in the problem.

We view economic development as critical to the long range solutions to homelessness crime and substance abuse. We propose the Congress give leadership to similar programs in every urban area with concentrations of homeless people.

Our organization proposes that the Congress consider creating enterprise zones in urban areas with homeless populations. We suggest that a coalition of government and business interests incubate small businesses made up of labor cooperatives formed by homeless people and those attempting to help them.

These coalitions would plan, organize, develop and incubate small businesses who would be given SBA loans, a series of SBA loans if necessary, and continuing long term technical assistance to insure those businesses ultimately succeed. We request a seed money grant of approximately $50,000 to support a land trust housing cooperative here in the skid row area.

I have a document which is too detailed to go into at this hearing, but I would be happy to supply the document and to answer questions that arise.

I brought with me one of our program participants, Mr. Thomas Gist who is available if there is any interest in speaking with Mr. Gist in answering questions.

Are there any questions?

Chairman HAWKINS. Well, I think your idea certainly has a lot of merit. I have no questions. I think it is innovative and creative. You had indicated that in some detail you would present it to the committee.

Do you have that prepared today?

Mr. NADLER. It is not prepared today, but it will be with you within the week.

Chairman HAWKINS. If so, we will keep the record so that it can be received. It will be in the official record as if it were presented today, and the staff will review it and we will obviously give you some comment on it.

Mr. NADLER. We have submitted an overview of our program and some of the documentation about what we are in fact doing at this time.

Chairman HAWKINS. Thank you, very much.

The next panel, job training and placement programs sponsored by service providers panel, and it consists of John Haley, Director of Mary Lind Foundation, Mr. Edward Eisenstadt, Director of Alcohol and Residential Services Volunteers of America. Bette Ripp, Director of Programs, People in Progress, Thomas Settle, Executive Director, Carring Hands Programs, Mr. James Schmidt, Executive Director of the Fountain House.

Would those witnesses be seated, and Mr. Haley, we will hear from you first.

STATEMENT OF JOHN HALEY, DIRECTOR, MARY LIND FOUNDATION

Mr. HALEY. Thank you Congressman Hawkins, Congressman Roybal, Councilman Bernardi for the opportunity, and I also thank you for convening this hearing.

As you suggested in the beginning Congressman Hawkins I will depart completely from my prepared text. I gave some printed copies and in the interests of time just spot some highlights.

Dr. Farr mentioned that 40 percent of the homeless have an alcohol problem. The Mary Lind Foundation for the record operates alcoholic recovery homes. We have done that since 1949 and believe we are the oldest operators of alcoholic recovery homes in the country.

Forty percent of homeless people have a drug problem. The population we serve comes from central Los Angeles, and of course they are all alcoholics, but 95 percent of our people are homeless. I would like to state in view of the testimony that has already gone ahead because almost everything I would like to say has been said.

We do basically in the process of job development the things that Martha Brown Hicks does. I am impressed that this is a joint committee on education and job finding because if you would just offer our people a job it would be a waste of time. We need an educational process first. And in order to bring about an educational process we find that it is most important to create an environment in which there is hope. For that reason I would like to emphasize the statement of Mr. Alatorre that warehousing is certainly not an answer.

I think we must create environment, that environment almost have to be residential, because if people are simply in a warehouse, I think they are going to endlessly go through the cycle. So we first educate our people in a process of recovery from alcoholism, and after we believe they have developed a strong personal program of recovery, then we educate them in the employment process because many of them do not know the characteristics for good employees.

And many of them do not have any job skills. Many of them have very bad work habits, and these things cannot come out of a warehouse situation. I was impressed also that they said that Martha Brown Hicks is endlessly encouraging her people, and that is part of the environment, that the people get encouraged.

So I would simply state that to be effective, if we could begin to think in terms of residential settings where the people receive enough education and enough hope that they really can turn their lives around, that then we make inroads.

In conclusion, just to kind of back this up, I will tell you that the county of Los Angeles welfare department did a survey of the people that completed our programs. They were interested in the effectiveness as far as welfare was concerned. They did not tell us they were making the survey, and the results showed that the people that they surveyed that had completed our program, six months later 83 percent of those had not reappeared on the welfare rolls.

And I will tell you that although that is a very nice statistic it did not surprise us, if the people get all the way through our program, we do not expect them to return to welfare. We expect them to remain independent and become constructive members of society. But especially also they now begin to have fine enjoyable personal lives.

That is all I will say and I thank you for the opportunity.

Chairman HAWKINS. Thank you, Mr. Haley. The next witness is Mr. Eisenstadt.

[Prepared statement of John Haley follows:]

PREPARED STATEMENT OF JOHN HALEY, DIRECTOR, MARY LIND FOUNDATION

It is a privilege for me to address this Committee on Education and Job Training for the Homeless. I am here in my capacity as Director of the Mary Lind Foundation, so a synopsis of what we do at Mary Lind seems to be in order.

The Mary Lind Foundation operates alcoholic recovery homes. Ninety-five percent of our clientele comes from the indigent population of Los Angeles County. We were founded in 1949 by an alcoholic who became sober, and began, in a small way, to try to help other alcoholics. His interests soon centered on people from downtown Los Angeles. He began a recovery home with six men. The undertaking grew slowly, but steadily. Today we have two large facilities that provide education and job training for 240 homeless male and female alcoholics. In June of this year we will open an additional facility that will house 100 more people.

I realize that this Committee was not convened to study the problems of alcoholism in Los Angeles, so I would like it to be known that our people are also homeless. We recently asked all of our residents the following question:

> "Would you have a place to go if, for some reason, you would have to leave Mary Lind?"

Ninety-five percent responded that they would have no place to go. Since the great majority of them are without financial resources, they would indeed be homeless.

Among the under-privileged, alcoholics are one of the most hopeful --repeat: hopeful, not hopeless--groups in society with which to work. It is essential that they develop a program of living that will allow them to exist comfortably without alcohol. Mere abstinence is not enough. The development of a sobriety program requires intense education. In consequence, we look upon ourselves as educators. We first provide a supportive environment in which recovery can take place. Then we provide education relative to the disease of alcoholism and about the recovery process.

Once an alcoholic has developed a strong personal program of sobriety, the transition to independent living requires that he or she find and maintain a job. So the second phase of our program is

Skills and Job Training for the Homeless

education regarding employment. We have learned, by sad experience, that if alcoholics come to us from skid row, and go to work prematurely, their working time is short lived. Merely offering them a job is not adequate. They need to develop structure in their lives. They need to be taught the characteristics of good employees. The development of employment qualities become adjuncts to the individual's program of sobriety. The environment helps to foster these qualities.

Many of our people need additional education on how to fill out job applications, prepare job resumes, when necessary, on how to behave on a job interview. Where there is a complete lack of job skills, we make linkage with community resources that provide skills training. Finally, our people require assistance in finding jobs, and we give them that assistance.

Our entire employment component is funded in part through a contract with the Community Development Department of the City of Los Angeles.

Some time back, the Department of Social Services in Los Angeles County made a survey of all of the people on welfare who had completed our program. We were unaware of the survey until it was finished. The survey revealed that six months after having completed our program, 83% of those surveyed had not returned to the welfare rolls.

At Mary Lind we do not try to offer services to all of the alcoholics on skid row. To those we do serve we try to offer something meaningful, so they do not have to return constantly through the same bleak turnstile of defeat.

I would like to make a generalized conclusion regarding all homeless. It is hardly even a retaining action to provide the homeless with mere shelter. Go to a shelter and announce that you have jobs for everyone there. Relatively few would be able to respond successfully. They need clothes, a shower, a haircut. After long unemployment they may lack basic employment habits. They may lack skills.

I suggest that unless we opt to recycle the same people endlessly through the system, we should begin to establish residential environments where a positive spirit of hope can be developed. In the long run, the cost of care per capita will be reduced.

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STATEMENT OF EDWARD EISENSTADT, DIRECTOR, ALCOHOLISM AND RESIDENTIAL SERVICES, VOLUNTEERS OF AMERICA, LOS ANGELES

Mr. EISENSTADT. Thank you, Congressmen, for the opportunity to speak to you today regarding homelessness which is a major problem here in Los Angeles and throughout America.

The Volunteers of America is a national social service organization established in 1896 and currently sponsoring over 400 programs in 170 communities across the country.

In VOA's effort to meet the needs of the poor, disadvantaged, sick and elderly, our mission has become more immediate because of the dramatic increase in the homeless population. It has also made our job more demanding when we are presented with budget cuts at every level of government.

Despite the governmental reductions nationally, the Volunteers of America has experienced a 35 percent increase in services rendered over the past four years. Much of this national VOA increase in services has been for the homeless population.

In cooperation with government, the philanthropic sector, and other charitable organizations we are attempting to address the need. In Los Angeles, over the past three years we have established 100-bed emergency shelter for homeless women and couples on skid row, a 27-bed emergency family shelter in Congressman Hawkins area of Willowbrook, and most recently a 52-bed emergency shelter for adults and families in Hollywood.

All of these programs were developed with the support and assistance of religious groups, the business community and local government. These programs also have received federal FEMA funds for renovation, furnishings and vouchers to offset operating costs. They would not continue to exist without volunteers at every level.

These volunteers range from the business community in Hollywood that have assisted in securing employment for over 80 of our homeless participants in the past four months. The church groups that have provided support in Willowbrook and a job training and preparation program for homeless women participants on skid row.

Despite these efforts, our local charitable organizations and local government are strained to the breaking point and require modest and targeted federal funding which will emphasize long term solutions and prevent future homelessness.

I will respectfully make a few suggestions in the following areas of homelessness. Support the authorization of additional HUD homeless aid programs targeted to expand the availability of emergency shelter and provide for transitional housing programs.

The second suggestion. Support increased allocations for Section 8 HUD low-income housing.

Number three. Support the house leadership with an increase in FEMA funds for the next fiscal period.

Number four. And this has been discussed before today. Take a hard look at the JTPA programs and how they can be tailored for the homeless. Currently, non-profit JTPA providers face a severe financial hardship in providing services for the homeless under JTPA.

Number five. Support the inclusion of specific funds for service delivery grants, for homeless alcoholic and drug dependent persons administered by the National Institutes of Alcohol Abuse and Drug Abuse.

Number six. Support legislation that requires local government to upgrade and preserve low-income housing with federal financial assistance.

In closing, I would like to point out that here in Los Angeles we have homeless being sheltered in city hall and in public tunnels. The vast majority of homeless subjected to this are not homeless by choice. Some are economically displaced. Some are chemically dependent or mentally ill, and most want to again become productive members of society.

They need help, and they need your help at the federal level. While you are taking testimony, please do not forget the seniors who are past their most productive years. We at the Volunteers of America in Los Angeles operate a program in Long Beach which provides one hot nutritious meal a day to seniors.

This may be the only balanced meal they receive. Most of these seniors are not homeless, but they are at the brink and just as helpless as the other groups I have mentioned. They all require your help and assistance.

Thank you, and I trully appreciate the opportunity and I want to especially thank Councilman Bernardi.

Chairman HAWKINS. Thank you, the next witness is Bette Ripp, Director of Programs People in Progress.

[Prepared statement of Edward Eisenstadt follows:]

PREPARED STATEMENT OF EDWARD EISENSTADT, DIRECTOR, ALCOHOLISM AND RESIDENTIAL SERVICES, VOLUNTEERS OF AMERICA, LOS ANGELES

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1. Support the authorization of additional HUD homeless aid programs, targeted to expand the availability of emergency shelter and provide for transitional housing programs.
2. Support increased allocations for Section 8 HUD low-income housing.
3. Support the House leadership with an increase in FEMA funding for the next fiscal period.

4. Take a hard look at the JTPA programs and how they can be tailored for the homeless. Currently, non-profit JTPA providers face a severe financial hardship in providing services for the homeless under the JTPA.

5. Support the inclusion of specific funds for service delivery grants for homeless alcoholic and drug-dependent persons administered by NIAAA and NIDA.

6. Support legislation that requires local government to upgrade and preserve low-income housing with Federal financial assistance.

In closing, I would like to point out that here in Los Angeles, we have homeless being sheltered in City Hall and in public tunnels. The vast majority of homeless subjected to this are not homeless by choice. Some are economically displaced, some are chemically dependent or mentally ill, and most want to again become productive members of society. They need help, and they need your help at the Federal level. While you are taking testimony, please don't forget the seniors who are past their most productive years. We at the Volunteers of America of Los Angeles operate a program in the Long Beach area which provides one hot, nutritious meal a day to seniors. This may be the only balanced meal they receive. Most of these seniors are not homeless, but they are at the brink and just as helpless as the other groups I have mentioned. They all require you help and assistance.

Thank You.

STATEMENT OF BETTE RIPP, DIRECTOR OF PROGRAMS, PEOPLE IN PROGRESS

Ms. RIPP. Councilman Bernardi, honorable members of Congress. Good afternoon.

Since 1974, People in Progress has been responding to the needs of the homeless indigent men and women who have problems with alcohol. Our programs have been developed in response to the needs presented by our clients and by clients in other programs as well as by the men and women on the streets, the homeless.

We believe in a continuum of services concept in our programming. From the first contact with a client on the streets to his or her admission into an alcohol free living center or other sober living environment, we provide appropriate programs or referrals for clients.

An important component for successful recovery and return to society as a productive member is our re-entry department. The client is admitted into this program after he or she has completed 45 days of continuous sobriety. An evaluation of their abilities and needs is done by qualified advocates and specialists who understand not only the disease of alcoholism but also are familiar with the dynamics of being homeless.

We find a lot of our clients are learning disabled due to fetal alcohol effects and fetal alcohol syndrome which they had suffered at childhood and in the womb.

Workshops and seminars designed especially for our clients are then conducted. Topics include resume writing job search, dress and hygiene, issues dealing with authority and keeping schedules.

After this segment is completed, the client then works with our job developer in seeking and obtaining employment. Overall 65 percent of our clients secure employment and maintain ongoing sobriety after completion of the program.

Currently, we are exploring more creative job positions for our clients as well as developing apprenticeship programs. We have found that employment is positively tied to successful recovery in our clients. Through stable employment that is suited to the skill level of the client, self-esteem is raised and motivation to continue successful sobriety and be a productive member of society becomes an important priority in the lives of these individuals.

Participants in our re-entry program learn how to give themselves permission to be a success through the development of their skills. Many of our clients are younger than they were three or four years ago. We also find an increased level of functional illiteracy as well as signs of learning disabilities. As a result, we design programs to be as individually tailored as possible given our budget and staffing pattern.

Many more of our clients today are enrolled in school to receive their GED previously. They are also enrolled in specific training programs as they bring virtually no skills with them in their recovery.

As a result, we have a more difficult population than before, yet we have a population that wants to make an investment in their lives. Our role is to help guide them in their new life.

Through advocacy, job development, counseling and skills education, we are able to achieve this. We want to do more and we will continue to do more. Yet, to do more will require a more creative approach, not only by our agency but also by the public and private employment sectors. This includes governmental agencies as well.

Suggestions for approaches to consider are listed. One. Establishment of satellite Employment Development Department offices to be located in high density neighborhoods. These would be smaller offices and deal only with specific matters. These matters could include casual labor assignments, preliminary applications for unemployment or an assessment center.

Two. Establishment of a business council in each councilmanic district. This would work with other businesses in developing an identification of jobs available and working with local non-profit agencies that provide employment programs for clients.

Implementation of a more nontraditional approach to addressing the needs of the homeless and unemployed.

We have provided solutions based on a value system for the homeless that may be operable in many parts of our society. We need to acknowledge this, scrap this system of solutions that have not worked and be responsive to the needs presented rather than have the homeless and unemployed fit into a pre-designed structure that is basically middle class in design and doomed for failure.

Number four. In order to achieve all of these, there needs to be a designation of federal funds sufficient to develop or enrich the successful programs already in operation. Beginning next week, People in Progress, is opening a women's center. This will be a 24-hour, 7 day a week drop-in and referral center for women only. There is no program like this in the country today.

After surveying 76 homeless women on skid row, and you have a copy of the survey and providing food and clothing for them for the past four years through a series of feed-in, clothe-in events, we have identified needs.

We are also employing women who have come from the row, and they will be able to work as specialists, trainees and advocates in this center. This is a non-traditional approach, yet this approach has worked for us for the past 13 years as we employ many staff who have previously enrolled in our programs in homeless.

How best to serve the needs of our clients then to have individuals who truly understand the situation. As a community we need to take a few more risks and spend some more money in local programs.

Thank you.

Chairman HAWKINS. Thomas Settle.

[Prepared statement of Bette Ripp follows:]

Prepared Statement of Bette Ripp, Program Director, People in Progress, Inc.

Respected members of Congress, good afternoon. Since 1974, People in Progress has been responding to the needs of homeless, indigent men and women who have problems with alcohol. Our programs have been developed in response to the needs presented by our clients and by clients in other programs as well as by the men and women on the streets, the homeless.

We believe in the continuum of services concept in our programming. From the first contact with a client on the streets to his or her admission into an alcohol free living center or other sober living environment, People in Progress provides appropriate programs or referrals for clients.

An important component for successful recovery and return to society as a productive member, is our re-entry department. A client is admitted into this program after he or she has completed 45 days of continuous sobriety. An evaluation of their abilities and needs is done by qualified advocates and specialists who understand not only the disease of alcoholism, but also are familiar with the dynamics of being homeless.

634 South Spring Street, Suite 400, Los Angeles, California 90014 (213) 622-3530

Workshops and seminars designed especially for our clients are then conducted. Topics include resume writing, job search, dress and hygiene, issues dealing with authority and keeping schedules. After this segment is completed, the client then works with our job developer in seeking and obtaining employment. Overall, sixty five percent of our clients secure employment and maintain ongoing sobriety after completion of the program.

Currently we are exploring more creative job positions for our clients as well as developing apprenticeship programs. Each month we provide awareness presentations to local community and business groups as well as program providers to educate them about our reentry division as well as solicit jobs for prospective clients.

We have found that employment is positively tied to successful recovery in our clients. Through stable employment,that is suited to the skill level of the client, self esteem is raised and motivation to continue successful sobriety and be a productive member of society becomes an important priority in the lives of these individuals. Participants in the re-entry program learn how to give themselves permission to be a success through the development of their skills.

Many of our clients are younger than three or four years ago. We also find an increased level of functional illiteracy as well as signs of learning disabilities. As a result, we design programs to be as individually tailored as possible given our budget and staffing pattern. More of our clients are enrolled in school to receive their G.E.D.,and in specific training programs as they bring virtually no skills with them in their recovery. Other clients find that they cannot or will not return to their former line of employment.

As a result, we have a more difficult population than before, yet we have a population that wants to make an investment in their lives. Our role is to help guide them in their"new" life. Through advocacy, job development, counseling and skills education we are able to achieve this. We want to do more, and we will continue to do more.

Yet to do more will require a more creative approach, not only by our agency, but also by the public and private employment sectors. This includes governmental agencies as well. Suggestions for approaches to consider are listed.

1. Establishment of satellite Employment Development Department offices be located in high density neighborhoods. These would be smaller offices and deal only with specific matters. This could be casual labor assignments, preliminary applications for unemployment or an assessement center.

2. Establishment of a business council in each councilmanic district. This would also be coordinated with each supervisorial district. The council might act as a task force in advising the councilperson of the job situation in the district and work with other businesses in developing an identification of jobs available and working with local non-profit agencies that provide employment programs for clients.

3. Implementation of a more non-traditional approach to addressing the needs of the homeless and unemployed. The homeless are its own society and have the same needs and demands as other societies within our community. They may have greater needs in certain areas, such as need for jobs, housing and health care. We need to explore and implement mechanisms to assist this

society as soon as possible. We have provided solutions based on a value system that may be inoperable in many part of this society. We need to acknowledge this, scrap this system and be responsive to the needs presented rather that have the homeless and unemployed fit into a structure that is basically middle class in design.

Designation of funds sufficient to develop or enrich programs (successful) already in operation.

People in Progress is opening a Women's Center next week. This will be a 24 hour, seven day a week drop-in and referral center for women only. There is no program like this in the country today. After surveying 76 homeless women on skid row, and providing food and clothing for them for the past four years through a series of "Feed-In/Clothe-In " events, we have identified needs. We are also employing women who come from the row as specialists, trainees and advocates. This is a non-traditional approach. Yet this approach has worked for us for the past 13 years as we employ many staff who were previously enrolled in our programs, or in other related programs. How best to serve the needs of the clients than to have individuals who truly understand the situation.

As a community we need to take a few more risks and spend some more money in local programs.

SURVEY OF NEEDS AS EXPRESSED BY WOMEN WITHIN

THE SKID ROW SECTION OF LOS ANGELES

Designed and Presented by Bette Ripp

1. I AM

_____	AFRO AMERICAN	33% or 25	BLACK
2.7% or 2	AMERICAN INDIAN	_____	NATIVE AMERICAN
_____	HISPANIC	42% or 32	MEXICAN
5.3% or 4	PUERTO RICAN	_____	LATIN AMERICAN
_____	ASIAN AMERICAN	_____	PACIFIC RIM ASIAN
17% or 13	WHITE	_____	OTHER

IF YOU WROTE DOWN "OTHER", PLEASE WRITE DOWN WHAT YOU MEANT._____

_____

_____

2. WHERE DID YOU SLEEP LAST NIGHT?

16% or 12	SHELTER	35% or 27	DROP-IN CENTER
28% or 21	HOTEL ROOM	_____	APARTMENT
7% or 5	STREETS	14% or 11	MOVIE THEATRE

_____OTHER, PLEASE WRITE DOWN WHAT YOU MEAN BY OTHER_____

_____

3. WHERE DO YOU USUALLY SLEEP?

14% or 11	SHELTER	37% or 28	DROP-IN CENTER
18% or 14	HOTEL ROOM	_____	APARTMENT
12% or 9	STREETS	12% or 9	MOVIE THEATRE

_____OTHER, PLEASE WRITE DOWN WHAT YOU MEAN_____

4% or 3 women listed a hospital as their usual place of finding a place to sleep, usually in a waiting room, 3% or 2 listed a building.

RIPP986RIPP986RIPP986

PAGE 2 SURVEY OF WOMEN IN SKID ROW SECTION OF LOS ANGELES

4. MY SEX IS 100% or 76 FEMALE _____ CHANGING SEX _____ DON'T KNOW

5. I AM 98% or 74 STRAIGHT(HETEROSEXUAL) 2% or 2 GAY, LESBIAN(HOMOSEXUAL)
_____ BISEXUAL _____ TRANSEXUAL _____ DON'T KNOW

6. MY AGE IS BETWEEN 3% or 2 18 - 24 -0- 49 - 54
11% or8 25 - 30 4% or 3 55 - 60
25% or 19 31 - 36 1% or 1 61 - 66
30% or 23 37 - 42 -0- 67 - 72
25% or 19 43 - 48 1% or 1 73 - 78

7. I GET SOME MONEY TO HELP ME LIVE. 100% or 76 YES _____ NO

8. I GET ABOUT 9% or 7 $1.00 - $85.00 EVERY MONTH
25% or 19 $86.00 -$160.00
2% or 2 $161.00 - 212.00
49% or 37 $213.00 - 270.00
2% or 2 $271.00 - 330.00
2% or 2 $331.00 - $400.00
6% or 5 $401.00 - 460.00
-0- $461.00 - $520.00
5% or 4 $521.00 - $580.00

9. I HAVE CHILDREN 57% or43 YES 43% or 33 NO

10. I CAME TO LIVE IN THIS AREA BECAUSE 25% or 19 I WAS REFERRED HERE
12% or 9 DROPPED OFF 5% or 4 WANTED TO
34% or 26 TOLD TO COME HERE 20% or 15 I DON'T KNOW
4% or 3 OTHER, PLEASE WRITE DOWN HOW YOU CAME HERE

RIPP986RIPP986RIPP986

PAGE 3 SURVEY OF WOMEN IN SKID ROW SECTION OF LOS ANGELES

PLEASE PUT A CHECK OR X OR SOME MARK TO TELL ME THE ANSWER THAT IS THE RIGHT ONE FOR YOU.

	NEVER	A LITTLE	SOMETIMES	A LOT	ALL THE TIME
I DRINK BEER,WINE, HARD LIQUOR	8% 6	20% 15	54% 41	14% 11	4% 3
I TAKE PILLS	4% 3	12% 9	18% 14	63% 48	3% 2
I TAKE GRASS, HASH	75% 57	7% 5	17% 13	1% 1	-0- -0-
I DO ROCK,CRACK OR COKE	66% 50	22% 17	9% 7	3% 2	-0- -0-
I HAVE STOMACH PROBLEMS	3% 2	14% 11	17% 13	62% 47	4% 3
I HAVE HEADACHES	-0- -0-	4% 3	53% 40	34% 26	9% 7
I HAVE PAINS	1% 1	8% 6	86% 65	4% 3	1% 1
I AM LONELY	3%	62%	24%	10%	1%
I HAVE A GOOD TIME	11%	12%	68%	6%	3%
I TALK TO PEOPLE	1% 1	36% 27	54% 41	9% 7	-0- -0-
I GET UPSET ABOUT THINGS	6% 5	30% 23	50% 38	11% 8	3% 2
I GO TO THE DOCTOR	82% 62	10% 8	4% 3	3% 2	1% 1

The numbers on the upper left half are the percentages and the number in the lower right hand of the box is the actual number of women responding.

RIPP986RIPP986RIPP986

PAGE 4 SURVEY OF WOMEN IN SKID ROW AREA OF LOS ANGELES

IF I COULD HAVE A CENTER TO GO IN THIS AREA, I WOULD LIKE IT TO HAVE THE THINGS I HAVE CHECKED OFF.

95% or 72 SHOWERS	12% or 9 READING ROOM
46% or 35 COTS FOR REST	94% or 71 TOILETS
59% or 45 NUTRITION (FOOD)	10% or 8 GAME AREA
12% or 9 CHILD CARE	71% or 54 CLEAN CLOTHES
41% or 31 CLINIC	75% or 57 REFERRALS
46% or 35 DPSS INFORMATION	67% or 51 INFORMATION
87% or 66 SECURITY	13% or 10 SOCIAL SECURITY INFORMATION
43% or 33 HELP	

THANK YOU VERY MUCH FOR YOUR HELP. PLEASE TAKE SOME MORE DOUGHNUTS AND BANANAS WITH YOU. I HOPE TO SEE YOU AGAIN. IN JANUARY THERE WILL BE FREE FOOD AND CLOTHES..NO QUESTIONS. YOU WILL GET A FLYER OR YOU WILL HEAR ABOUT IT FROM OTHER PEOPLE. YOU CAN COME AN SEE ME AT 634 SO. SPRING STREET ON TH 4TH FLOOR, ROOM 400. I WON'T ASK YOU ANY MORE QUESTIONS AND I WILL NOT REPORT YOU TO ANYONE.

STATEMENT OF THOMAS A. SETTLE, VICE PRESIDENT, WINGS OVER JORDAN, INC., AND EXECUTIVE DIRECTOR, CARING HANDS PROGRAMS

Mr. SETTLE. Thank you, Mr. Chairman. Congressman Roybal, Congressman Martinez, and Councilman Bernardi.

It is clear that real solutions to the problems of homelessness which is a problem which affects every metropolitan community, cannot be achieved without considering employment of those homeless who can work.

After several studies for homeless population in Los Angeles conducted by Dr. Richard Roper, now of the University of Utah, but formerly of UCLA, and Dr. Roger Farr who testified earlier.

A significant portion of the homeless population in Los Angeles is able to work. Between the two studies they identified approximately 35 percent of the homeless population as employable, and of that percentage 46 percent had held jobs for the past five years.

Unfortunately, no effective mechanism has been found to bring the homeless who are employable and who desire to work back into the mainstream of the workforce. True many of the homeless work on casual labor basis, that is day work found by jobbers doing such things as delivering circulars, yard work, and some unskilled labor found on the docks and in the railroad yards. But this labor for pay is uncertain.

For many years the federal government has funded employment training programs known as the Joint Training and Partnership Act. These programs were all admirable in their attempt to bring hard to place individuals back into the workforce are not capable for the most part of dealing with complexity of problems faced by the homeless individual seeking employment.

It is axiomactic that without a permanent address, and access to a phone, finding a job is very slim. The homeless of Los Angeles and most everywhere else face these problems on a daily basis. Few employers look favorably on individuals applying for work who are not properly dressed. Providing clean, serviceable and presentable clothing without access to facilities to wash clothes makes it near impossible for most homeless people to have the proper attire to apply for employment.

Most employers do not look favorably upon those who have no access to facilities for showering, shaving and personal hygiene. A good number of JTPA agencies are not set up to provide basic necessities for those who are homeless. It cannot provide for the most part food, clothing, shelter, washing facilities or personal hygiene.

They are set up to provide employment placing and training an activity which presumes that basic needs are already met. Additionally, they are required to meet quotas of placements on a quarterly basis. With a quota requirement, it is difficult for the normal JTPA agency to provide the types of employment rehabilitation that are also needed by many homeless people.

Caring Hands is a public benefit service of Wings over Jordan and has been serving homeless and low-income people in Los Angeles County since 1984. Wings over Jordan has been providing services to needy people in a variety of forms throughout the United States since 1934.

The types of services Wings over Jordan provides through its Caring Hands programs includes basic life support in the form of food, clothing and shelter. And in 1986, the last calendar year closed, served 32,000 households.

Not all of these households were homeless, but more than 40 percent were without permanent housing evidenced by the 14,000 nights of shelter provided during that year. Through the counseling portion of Caring Hands we have noticed that mere referral of clients to public employment programs such as those operated by the state of California employment department, or those provided through federal programs such as the Veterans' Administration has had little effect in helping our homeless clients achieve permanent employment.

Many of the problems encountered have been listed and mentioned before. While 12 percent of the population surveyed as indicated above have a college education and 64 percent of the same population were found to have completed a high school education, many of the homeless clients who seek our services we find to be functionally illiterate.

Few of the JTPA programs have the time to assist those clients with remediation even though the Los Angeles school system and the Los Angeles junior college system have JTPA programs, they too seem incapable of reaching the vast majority of homeless clients.

Part of their inability to reach the majority of homeless clients rests with the need of the client to spend so much of his or her time seeking shelter and food. And having very little time to seek assistance from public or private agencies which could help them receive a modicum of literacy.

Few of the social service providers to the homeless have the time, staff, or funding to assist the client with basic remediation. It seems clear that a better and more productive use of resources needs to be brought to bear so that the homeless individual can have the opportunity to successfully seek employment with a realistic expectation on that client's part that employment can be found.

To accomplish this as a society we must become comfortable with the reality that employment rehabilitation is an acceptable approach to helping to solve the problem of homelessness. To this end, Caring Hands has devoted much time and effort in helping clients prepare themselves to re-enter the work force without the use of public monies.

This effort of Caring Hands is known as Job Fare, and as a matter of record has been funded by the Corporation of the Cathedral of St. Paul, the Anglican Diocese of Los Angeles.

It is through our Job Fare program and job preparation workshops which help clients come to realistic appraisals of their skills, talents and needs. That we have been successful in the past year and a half in placing some 60 homeless people back into the workforce without subsidy to the employer.

The average length of time required to accomplish this rehabilitation is eight months. Our rehabilitation program includes transitional housing, access to job phones, food, clothing, a mailing address, referral to appropriate educational institutions for remedi-

ation, assistance with obtaining public assistance benefits, and assistance with obtaining medical and dental care.

We therefore call on our elected officials to consider employment rehabilitation models for the homeless as part of a viable alternatives to homelessness and incorporate such models into funding availability through all homeless housing and job training and placement funding sources.

Further, we note that little money is spent on job development for the homeless population, and we call on our elected officials to provide specific funding to develop models of cooperation between private and non-profit sectors serving the homeless and the private industry so that a conduit can be formed to assist homeless clients with specific job sources.

This process of job development cannot be one of just finding a specific job for a specific client, now done by most JTPA programs, but must be one which encourages private industry to make room for those who are homeless by educating the private sector that some of the temporary conditions which can make the homeless clients appear different can and will disappear when that client has sufficient funds to rectify his or her situation.

If it is the goal of this society to assist each individual who so desires to achieve his or her potential as a contributing member of this society, then a substantial commitment must be made to the poorest of the poor, the homeless among us, to assist them to self sufficiency through employment, affordable housing, child care, and decent medical benefits. Thank you.

Chairman HAWKINS. Thank you.

[Prepared statement of Thomas Settle follows:]

PREPARED STATEMENT OF THOMAS A. SETTLE, VICE PRESIDENT, WINGS OVER JORDAN, INC., AND EXECUTIVE DIRECTOR, CARING HANDS PROGRAMS

CONGRESSMAN AUGUSTUS HAWKINS, CHAIR COMMITTEE ON EDUCATION AND LABOR

CONGRESSMAN ED ROYBALL, CHAIR HOUSE SELECT COMMITTEE ON AGING

CONGRESSMAN MARTINEZ, CHAIR HOUSE SUB-COMMITTEEE

It is clear that real solutions to the problems of the homeless, a problem which affects every town and metropolitan city of this country, cannot be achieved without considering the employment of those homeless who can work. After several studies of the homeless in Los Angeles conducted by Dr. Richard Roper, now of the University of Utah, but at the time of his work a facility adjunct at UCLA, the work of Dr. Roger Farr, Assistant Director of the Los Angeles County Department of Mental Health, a significant portion of the homeless population is able to work. Between the two studies they identified approximately 35% of the homeless population as employable. And of that percentage, more than 46% had held jobs in the past 5 years.

Unfortunately no effective mechanism has been found to bring the homeless who are employable and who desire to work back into the mainstream of the workforce. True, many of the homeless work on a casual labor basis: i.e. day work found by jobbers doing such things as delivering circulars, yard work, and some unskilled labor on the docks, and railroads. But this labor for pay is uncertain. For many years, the Federal Government has funded employment training programs known as the Joint Training and Partnership Act (JTPA). These programs while admirable in their intent to bring hard to place individuals into the workforce are not capable, for the most part, of dealing with the complexity of problems facing the homeless individual seeking employment.

It is axiomactic that without a permanent address, and access to a phone, finding a job is very slim. The homeless of Los Angeles and most everywhere else face these problems on a daily basis. Few employers look favorably on indiividuals applying for work who are not properly dressed. Providing clean servicable and presentable clothing without access to facilities to wash clothes makes it near impossible for most homeless people to have the propoer attire to apply for employment. Most employers do not look favorably on those who have no access to facilities for showering, shaving, and personal hygenie. A good number of JTPA agencies are not set up to provide basic necessities for those who are homeless; they cannot provide, for the most part, food, clothing, shelter, washing facilities, and places to clean-up. They are set up to provide employment placement and training, an activity which presumes that basic needs are already met. Additionally, they are required to meet quotas of placements on a quarterly basis. With a quota requirment, it is difficult for the normal JTPA agency to provide the types of employment rehabilitation that are also needed by many homeless people.

Caring Hands is a public benefit service of Wings Over Jordan Inc., and has been serving homeless and low-income people in Los Angeles County since 1984. Wings Over Jordan has been providing service to needy people, in a variety of forms, throughout the United States since 1934. The types of services Wings Over Jordan provides through its Caring Hands Programs include basic life support in the form of food, clothing, and shelter serving, in 1986, nearly 32,000 households. Not all of these households were homeless but more 40% were without permanent housing evidenced by the 14,000 nights of shelter provide during calendar year 1986. Through the counseling portion of Caring Hands, we have noticed that mere referral of clients to public employment programs, such as those operated by the State of California's employment department, or those provided through Federal programs such as the Veterans Administration, has had little effect in helping our homeless clients achieve permanent employment. Many of the problems encountered by the clients have been listed above.

While 12% of the homeless population surveyed in skid row, through the studies cited above,

were found to have a college education, and 64% of the same population were found to have completed a high school education many of the homeless clients who seek our services, we find to be functionally illiterate. Few of the JTPA programs have the time to assist those clients with remediation. Eventhough the Los Angeles School system, and the Los Angeles Junior College Sytem have JTPA programs, they too seem incapable of reaching the vast majority of homeless clients.

Part of their inability to reach the majority of homeless clients rests in the need of the client to spend so much of his/her time seeking shelter and food that little time is left to seek agencies, public or private, who could help them achieve a modicum of literacy. Few of the social service providers to the homeless have the time, staff, or funding to assist the client with basic remediation.

It seems clear that a better and more productive use of resources needs to be brought to bear so that the homeless individual can have the opportunity to successfully seek employment with a realistic expectation, on that client's part, that employment can be found. To accomplish this, as a society, we must become comfortable with the reality that employment rehabilitation is an acceptable approach to helping to solve the problem of homelessness. To this end, Caring Hands has devoted much time and effort in helping clients prepare themselves to re-enter the workforce, without use of public monies. This effort of Caring Hands is known as Job Fare. It is through our Job Fare program and job prepration workshops, which help clients come to realistic appriasals of their skills, talents and needs, that we have been successful in the past year and a half of placing some 60 homeless people back into the workforce without subsidy to the employer. The average length of time required to accomplish this rehabi-litation is 8 months. Our rehabilitation program includes transitional housing, access to job phones, food, clothing, referral to appropriate educational insitutions for remediation, assistance with obtaining public assistance benefits, and assistance with obtaining medical/dental care.

We therefore call on our elected officials to consider employment rehabilitation models for the homeless as part of the viable alternatives to homelessness and incorporate such models into funding availability through all homeless houisng, and job training and placement funding sources. Further we note that little money is spent on job development for the homeless population. And we call on our elected officials to provide specific funding to develop models of cooperation between the private non-profit sector serving the homeless and private industry so that a conduit can be formed to assist homeless clients with specific job sources. This process of job development cannot be one of just finding a specific job for a specific client, now done by most JTPA programs, but must be one which encourages private industry to make room for those who are homeless, by educating the private sector that some of the temporary conditions which can make the homeless clients appear different can and will disappear when that client has sufficient funds to rectify his/her situation.

If is the goal of this society to assist each individual, who so desires, to achieve his/her potential as a contributing member of this society, then a substianial committment must be made to the poorest of the poor--the homeless among us-- to assist them to self-sufficency through employment, afforable housing, child care, and decent medical benefits.

VOICE. Excuse me, sirs. I am a client. I am a member of the California and Los Angeles network of Health Clients, and I would submit to you that it is very unfortunate that with all due respect to all these people that run programs, that no clients have been allowed to speak.

And I would ask that either I be allowed to speak or with all due respect that the record be allowed open so that I can submit in writing——

Chairman HAWKINS. Well, the program is nearing the end. There are two individuals who asked me to speak before you did.

VOICE. I understand, sir. If I am not allowed to speak, I would like to ask that the record be left open because it is written in pencil and I cannot photocopy it. I would like to——

Chairman HAWKINS. Well, I do not know. The only thing we can do is wait until after the panel is completed and divide up some time. It can only be a minute or two. Unfortunately, we are running much behind as it is.

If we had a hearing everyday, there would be some people we would never reach who would tell you that unfortunately you did not reach me, and we are doing the best we can, and the only thing we can do is go through this schedule, and if anybody is left here, we will try to accommodate him.

VOICE. I just wanted to let you know that I would like to speak if possible.

Chairman HAWKINS. Yes, but I am sure that there are many others who would like to speak also. We will see. Let us complete the panel and then go to the two other individuals who asked permission to speak. I do not know who they are. They may be clients or they may be other persons.

But we will do the best we can. That is all I can assure you. Mr. Schmidt, I think we still must reach you.

He is not in the audience. I see. Questions then of the panel.

Mr. ROYBAL. I have no questions.

Mr. MARTINEZ. I have no questions.

Chairman HAWKINS. Well, you have been very thorough in your statements. I wish to commend you on your statements. It is obvious you are reaching a clientele that is not reached by JPTA and some of the other agencies.

I think the subcommittee headed by Mr. Martinez is going to review that entire subject this year. I think your testimony will be very helpful to the subcommittee. We appreciate it and thank you very much.

Now, a gentleman earlier in the day had submitted a statement. Yes, you. I am sorry. What is your name? Would you come up and identify yourself, please?

Mr. SILVA. Mr. Chairman, my name is David Silva.

Chairman HAWKINS. Would you identify yourself for the record, and you have submitted a statement and could you confine your statement to let us say a minute?

Mr. SILVA. Sure.

STATEMENT OF DAVID SILVA, NATIONAL COORDINATOR OF NATIONAL UNIT OF HOMELESS, SECRETARY TREASURER OF LOS ANGELES UNION OF THE HOMELESS

Mr. SILVA. Sure. My name is David Silva. I am national coordinator of the national unit of the homeless. Locally, I am secretary treasurer of the Los Angeles union of the homeless.

And it is very hard to be, in a minute to try to lay out the basic concepts that are in this letter. This letter was presented and sent to every congressman and senator dated February 14, so your offices should have received this letter far before this afternoon when I submitted it to you.

I will let you read the letter. The letter basically states our concerns that the shelter system is expanding and becoming an alternative to housing. Especially when you consider that the federal government in the last five or six years have cut back over $20 billion in the construction of low income housing in section 8 aid and so on and so forth.

That we see that as a very serious and critical problem in dealing with homelessness. But I would just like to say that we have a workable program. We have a program in Philadelphia that was an agreement between the city of Philadelphia and the union in Philadelphia which has turned over 200 homes and apartment complexes to homeless people to begin to house people.

Because the shelters, the system is—I do not care what city you go into, is the most undignified, de-humanizing process that people can be put into. With the exception of Nancy Mintie and maybe Dr. Farr, it is very difficult for me to sit through—to listen to a lot of the discussion that went on.

You have got to hear the other side of the testimony. You have got to let homeless people testify. The Weingart, the St. Julias Center, the Transition House, the SRO hotels run by—and every one of them we get daily complaints of beatings of harassment, of militaristic type running of these shelters, rapes, stealing of people's money, the stealing of people's property.

I mean the conditions, the shelter system in Los Angeles that I am best familiar with is more a system of control than it is a system of resolving the problem of homelessness. It used to be and we are not totally against shelters. There is a need for emergency shelter. There is a need for a temporary situation where people that fall into homelessness need a little bit of assistance to get back on their feet, get a job and back out into the mainstream of society.

But it is becoming a typical story now that people are staying three, four, five years into these shelters that are meant to be only a short term solution to people that fall through the cracks.

The problem is tremendous unemployment in this country. The problem is a lack of affordable low-income housing. Los Angeles, the housing prices in this city, the elimination as a result of indiscriminate redevelopment projects in this city is cutting out, is making more and more homelessness.

And one thing I really wanted to express to you that the Veterans Administration, HUD, FHA all have tremendous amount of housing stock that could be immediately be utilized as temporary

shelter for especially homeless families but also individuals, that can immediately.

In this Philadelphia program, the Veterans Administration opened up its entire inventory stock to this program to begin to utilize those homes. When we took over federal housing here in L.A. we ran into homes that had been beautiful homes, beautiful condition. It has been sitting there empty three, four, five years, owned by the federal government, kept up by us.

And it is just absolutely ridiculous that there is literally thousands of homes in Los Angeles and apartment units both from the federal level, the state level from the county level and from the city level that are sitting there empty. Nothing utilized.

And literally thousands of people can be put into those houses with far less expenditure of funds. Because you look at—with all due respect to Councilman Bernardi who has done a tremendous amount of work for homeless people in Los Angeles. He has spoken out and we give him that recognition.

But to spend $500,000 on a 90-bed shelter to us does not make any kind of economic sense. You know, to be putting people in shelters for that amouht of money when we can utilize a fraction of the money that is being spent to renovate these homes, create the kind of job programs that can put homeless people to work and put them back into housing.

The only other area of homelessness is just the mentally ill, especially the chronically mentally ill need very specialized and specific programs. But the vast majority of the homeless today as I am sure you know, auto workers, steelworkers, coal miners, electricians, skilled workers and unskilled workers, people who if you give them the alternative of a home to a shelter take a home.

As a matter of fact, the vast majority of homeless people in Los Angeles pick the streets to the shelter system in Los Angeles because of rat infested hotels, because drug dealings and beatings that go on in the hotels and the entire shelter system. And I would like to suggest that before you allow any funds, just like the JP program that Congress should investigate this particular shelter system and I am sure many across the country before you allow any more money to go into them.

I think you should allow homeless people to testify as to what is going on in these places. And I think you will begin to look at it——

Chairman HAWKINS. Well, I express our appreciation to you and in response let me tell you—let me assure you that the hearing this afternoon is not the only hearing we have held, not the only one we intend to hold. We have gone out to visit sites, we have had some of our colleagues roam the streets at night to talk to the homeless.

We have gone into various settings and what not. We are hearing from everyone including the homeless themselves. I just want to assure you that if we have not heard from anymore than what you think we should have heard from that you should look at the record and see the number of witnesses that we have listened to. We will continue to do that.

We have only a certain amount of time available, and so we cannot possibly one day listen to more than what we have listened to today. There is a point of exhaustion that you just cannot go on.

Mr. SILVA. But every person on this list that you organized to listen to testify, none of them have ever been homeless. None of them—there is not one homeless person on this list who can testify for themselves who have gone through this.

Chairman HAWKINS. What I am saying is, we have listened to homeless themselves, not necessarily today, but you are assuming that because these people have not been homeless today and we have listened to them that we have not listened to homeless people.

What I am telling you is that on other occasions we do listen to homeless people. We will continue to do so. But do not judge it merely by fellows that we have listened to today. Obviously we should listen to the elected official. We should listen to those who operate programs as well.

We should listen to everyone, and that is what we are trying to do.

Mr. SILVA. Skid row like homeless——

Chairman HAWKINS. If you would listen to some of the other who are going to protest if they don't be heard from also.

Mr. SILVA. All right. I thank you for the opportunity to let me speak.

Chairman HAWKINS. Thank you, and the record will be kept open. Now, there was another gentleman over here. Well, we are going to listen to several. The gentleman on the front row. You had a statement. Would you come to the table also and this—is this it? Were you seeking recognition? The gentleman seeking recognition?

VOICE. Yes, I was.

Chairman HAWKINS. Would you come to the table, please? Well, we are going to try to allocate the time. We are going to give you a minute or two each, but we are getting to the point where we have got to terminate the hearing.

We have been here since 9:00 o'clock this morning, and we have got to terminate very soon. Now, we are going to listen to you two. You can file a statement, and we will keep the record open so that if there is any additional information you wish to submit, you may do so and it will be in the official record.

STATEMENT OF GEORGE MOUNT

Mr. MOUNT. My name is George Mount. I live in Boyle Heights, East L.A. The only official job I have ever had was five years as a member of the Mexican American Education Commission and I lobbied for the first half million dollars we got for the L.A. area.

But we are not on that subject now. That is a little for validity. In 1935, when I was learning to fly, I flew over Newark, New Jersey at about 1,000 feet and they had one of the famous Hoovervilles. And it was a massive thing made mostly of cardboard, a huge village at the edge of a dump.

Now, I went back 20 miles from there to my hometown, and almost nobody including the unemployed could believe what I had seen. And I believe that is what we are facing today. People, 10, 20 miles a few blocks from here do not know what is going on.

Now, in 1938, three years later, I had the experience took a little over a month of traveling from here to New York looking for work, hitchhiking, freighting, getting shot at by railroad cops, the only time I heard bullets whiz even though I had four years in the Army later.

And the one thing I want to say is about the cold, the cold. When we heard about the cold here in L.A. a few months ago it jarred a lot of us who knew there were people sleeping out to go through our own houses and dig up pads and dig up cushions and rugs and clothes that were good that we had no intention of giving out, and a lot of us brought it down and gave it to the people on the row.

I brought four mats down one evening, and there was a black woman, and two black men and one Indian man without shoes, and they were just tickled to death, they had something to lay on.

Then when I hear—and I ran across good people and bad people on the trip across the country. I never want to do it again, but I am glad I experienced it. I was 20 years old in 1938. One time it was raining in Louisiana. I ran and jumped into a car that was open.

I slept all night, little hick town. I ran out in the morning, I ran across the street to get a cup of coffee and a guy in civy clothes with a constable's badge on said, son, did you have a good sleep? I said, yes, sir, I slept in that car over there. He said, I know. I saw you get in. It was my car.

I will never forget the man. All right. Atlanta, Georgia, I was going across the area there traveling at night and think I could sleep in the park during the day to be safe and I got whacked over the shoe by a cop there and told to get moving. I think that is happening here in L.A. from what I am seeing about the sweeps. Now, I think our national and local priorities are loused up bad. When people are cold, they do want a pad under them. The permission to sleep out isn't enough. They are freezing. Some died here in L.A. They need more than permission to sleep on the sidewalk. I don't believe we should have sweeps and clean out the things that people have donated for them until you have got some alternative to put them up.

I had an Indian guy from Guatemala sleeping in my car at night while I used it in the daytime. He had nowhere else to go for a month. He finally got a place to go. This is what is happening two miles from here.

I have got a thing here having nothing to do with this subject. I am going to give it to Congressman Roybal with some comments that I got in the mail so that he can look it over. The rest are my notes. He can throw away. This is weird too, but it ties in with our national and local priorities stink. I never thought after Roosevelt was president that we would ever see people sleeping on the streets again.

I never thought so. I am awfully naive. I am damn near 70 years old. I am still naive and I can't understand why. I got this thing here from Gallaudet College or university in Washington, D.C. Maybe you men can look it up. It says it is the only college for deaf people in the world. I can't believe that. Maybe we are not looking at other countries, but if it is it is a damn shame. Why haven't we got local ones. Why couldn't we use this as a base. It is just the

priorities that I am dealing with, the same as we are here. And have them all over.

I made the last note. The cost of illegal operations in Central America should run the whole program. And I think that about yours too. And I wish you well.

Chairman HAWKINS. Thank you. If you could identify yourself for the record and can you be as brief as possible.

Mr. QUAIL. Thank you.

STATEMENT OF DAVID QUAIL

Mr. QUAIL. I will be as succinct and speak as fast as I possibly can. I want to thank you for allowing me to speak. My name is David Quail. I am a member of the Los Angeles and California network of mental health clients. I am project return member which is affiliated with the Association of Los Angeles County.

And I am on the advisory committee, was one of the grant writers and the founder of the benefits assistance clients urban project which is a client run benefits assistance program, I think one of the first in the country if not the first which we got by writing up and being given a grant from the Los Angeles County Department of Mental Health here in Los Angeles.

The threat of the city of Los Angeles to sue the County of Los Angeles——

Chairman HAWKINS. Do you have a written statement? Would it not be better for you to submit the written statement and just comment on the comment?

Mr. QUAIL. Okay. I will comment briefly rather than read through it.

Chairman HAWKINS. The statement we can read, you see, because it will be in the record.

Mr. QUAIL. I would have to submit it at a later date because it is in pencil and it won't copy.

Chairman HAWKINS. Well, we will keep the record open so if you submit it to us within two weeks, we will see that it is officially recorded.

Mr. QUAIL. Briefly, the only threat that is left by the City and County not engaged in literature is the threat to turn back the clock some 20 years and go back to the wholesale more easily legislated committing people on the streets, mental patients for 72 hour holds and then keeping them even longer without hearings.

As recently as November I was accused of being dangerous and was thrown in the hospital. I was accused of having delusions of being a musician even though several times I have been on TV singing and playing guitar.

As Mr. Bernardi said and I would like to emphasize, this country has never when they de-institutionalized mental patients, never put a real commitment into building community facilities. Never. They just turn people out into the street, none without having worked. Now they want to say, okay. Let us get these poor people out into the street. I say, no.

Instead of doing that, let us finally once and for all for the first time since clear back in the Kennedy Administration let us build the community facilities. Let us build more section 8 housing. That

is what we need. We need section 8 housing. We need to build where the government needs to supplement low cost housing and the shelters that you speak about. They can't be short term and they can't be just for inclement weather.

The people want a chance to get out of homelessness and out of the revolving door, they need full time all weather shelters which allow them to stay for long periods of time not two weeks, not five days but maybe two months to six months provided that they show that they are doing something and not just taking advantage of it.

And they also, one thing that nobody has mentioned, you need a place to store your things. Have you ever tried to apply for a job with a bedroll and plastic bags? Or worse yet, because I was fighting an eviction and a restraining order trying to kick me out of where I was living recently in Pasadena.

Have you ever tried to convince a judge of your credibility when you have not slept for several days and you come into court grubby, with your hair all messed up and you have got six plastic bags, three in each hand with all your clothes and stuff in it. They laughed you out of the courtroom.

The other thing, another thing that I would like to mention is the housing and the sanitation laws when people rent housing to people for profit are not being enforced. It is a joke. You call in the police against the landlord. You call in the housing department. You call in the health department. They laugh in you face. They allow the landlords to assault you, batter you, break in your door, steal your property and they don't do anything. And if you complain, they say, do you want to go back to the hospital?

I also think one thing that has not been mentioned, please increase the minimum wage. It is insane. People can't make it on the minimum wage now. It has not been changed now for a long time. Briefly, I would like to mention too. Single women. They need affordable child care and they need child support orders from courts enforced. They need the money or they end up on the street with their children.

Chairman HAWKINS. Well, now I think we'll have to ask you to terminate your remarks just as rapidly as possible.

Mr. QUAIL. Okay. Briefly, I would like to say that 60 day penalties are insane and ought to be done away with. If any penalties at all, they should be graduated according to the degree that people are sloughing off. And I think too that either the state or the federal governments ought to supplement county general relief amounts so that they can be uniform. At least within the state they should be uniform county to county so that people don't migrate to Los Angeles that they put the relief up because everybody wants more money. Okay. There has got to be some way so that the county only pays so much and it is supplemented from a higher level, like I said.

Finally, I would like to say something that is more of a broad thing and that is that our creator mandated us to multiply and replenish the earth. He did not send us out into space. Our Constitution mandates that we secure the blessings of liberty for us and our posterity. It did not tell us to deplete the resources of the earth so that there is nothing left for future generations.

I would say that one of the main things we can do to be a godly nation, truly godly is to get out of the heavens, put the money that is going into the space, to take care of our own, to build houses, to create jobs, to as they said earlier, have money for clothing, for alarm clocks, for bus passes. You know, when you are started.

And one last thing I would like to mention is this.

Chairman HAWKINS. Well, now we have allowed you to tell us five additional things. You are going to exhaust if you don't bring it to some conclusion and allow this gentleman an opportunity to talk.

Mr. QUAIL. OK. I will say one last thing then I will be silent. One other thing that is needed is first and last funds. Whether it is grants or interest free loans. Some people get work. They can afford rent but they can't afford the first, last and key deposits and et cetera. And that is something that this county has not done, but a newspaper the L.A. Weekly has done. I say that that is something the government should do especially in a state that has a billion dollar surplus as far as I know.

Chairman HAWKINS. Thank you. Now, you had something to submit for the record.

STATEMENT OF NICK BRKICH

Mr. BRKICH. There is no question that I do have something I think to offer. And Mr. Chairman, my name is Nick Brkich. Last name is spelled B-R-K-I-C-H.

For the sake of brevity—are you listening? Can you hear? For the sake of brevity I would like to direct this question to Congressman Roybal as Chairman of the Select Committee on Aging.

Chairman HAWKINS. All right. What is your question, sir?

Mr. BRKICH. First of all, the purpose, I am enrolled in the Medicare program. Secondly, I am also a client of the L.A. USE mental health outpatient clinic. There is a provision in Medicare on page 29 referring to comprehensive outpatient rehabilitation facility services where only $250 a year is their maximum amount allocated for people who fall into this particular case, you know, being on Medicare and a client of the outpatient facility at County USE known as Grant Hall.

And my question to Congressman Roybal, in the harsh and oppressive environment of the Reagan Administration, what can I and others like me similarly situated in this particular field, you know, in this class, what can we look forward to in terms of the elevation of the amounts? At the present it is only $250 dollars as a provision of Medicare? Am I wrong?

Mr. ROYBAL. Well, that question will of course require a long answer, but I think very simply put under this administration there will be no increase. It will have to wait until such time as it is possible to reevaluate the situation and then make proper recommendations and not have to suffer the possibility of veto.

Mr. BRKICH. Well, what happen to the river of people where the flotsam and the jetsam will be ejected from the stream of life because of the—or the inabilities of those people in position of powers [sic] to bring meaning to life itself with added monies that should

be allocated for treatment of those people who fall in this particular class.

We have nothing to look forward to in the future?

Mr. ROYBAL. Not as long as this administration is in power. We will have to wait for the next administration.

Mr. BRKICH. Well, don't you think that this issue itself should be projected during the future years or not?

Mr. ROYBAL. We have been fighting for a change for a long time, but so far under this administration we cannot do anything. Did you vote for Mr. Reagan?

Mr. BRKICH. There is something that I want to call to your attention. In a democracy your ballot is secret.

Chairman HAWKINS. The hearing——

Mr. BRKICH. Would you care to answer that particular remark, Congressman? Thank you very much.

Chairman HAWKINS. I think Mr. Roybal has given you a better answer than you gave him, but the hearing is completed and thank you very much.

[Whereupon, at 5:33 p.m., the committee adjourned.]

[Material submitted for inclusion in the record follows:]

Part II/Thursday, January 22, 1987

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A Times Mirror Newspaper

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Hope for the Homeless

The Los Angeles City Council proved its compassion by allowing some of the homeless to take warm, dry refuge for three nights in the council chambers at City Hall during the recent cold spell—but only after people had died. Mayor Tom Bradley, pragmatic and cautious, had initially opposed opening public buildings because of the costly liability risk.

Councilman Zev Yaroslavsky made the motion that finally opened the doors, but Councilman Ernani Bernardi's proposal to turn vacant public buildings into temporary or permanent shelters has been going nowhere for two years. And Councilman Richard Alatorre's motion to allow the homeless to sleep in the lobbies of public buildings died last March when the weather was balmier and the problems of the homeless were easier to ignore.

There is no accurate count of the men, women and children who have no addresses but live in Los Angeles, no census of despair, but there are estimates that 34,000 to 80,000 homeless people live somewhere within county boundaries. And the demand for emergency housing jumped by 50% in Los Angeles last year, according to a survey released last month by the U.S. Conference of Mayors. That was the largest increase in the 26 big cities studied.

Who is responsible?

Homelessness is a national problem, a county problem, a city problem and a neighborhood problem. A combination of public and private responses, ongoing and substantial from institutions and individuals, is needed to provide more emergency shelters, more meals and more medical attention. Those are short-term responses.

In California the counties provide for the health and welfare of people who have no other resources. Los Angeles County expects to spend $185 million this fiscal year on health services, mental-health attention, general relief grants, food and shelter. Los Angeles Supervisor Ed Edelman wants to do more, and more is needed. He has asked the county's chief administrative officer to provide a plan for more emergency shelter. That report is due today. We hope that the study, which warded off no chill during the recent cold spell, will help the county to increase its response.

To its credit, the city has spent $60 million on the homeless over the last two years. The Los Angeles Community Redevelopment Agency has provided substantial financial backing, including an additional $2 million just last month, for housing for homeless families and other people in need. The mayor has backed and expedited those efforts. But the city can also do more.

The City Council is scheduled on Friday to consider Bernardi's proposal that would convert an old electronics repair shop on San Pedro Street into a temporary facility for 90 people, along with other proposals to address the emergency. While these urgent responses deserve careful consideration, what happens when the council chambers are no longer open?

Long-term responses offer more hope. The Greater Los Angeles Partnership for the Homeless, an organization that takes no government money, is working to raise $4 million in the next three years to end the cycle of homelessness. Led by Bradley, Roman Catholic Archbishop Roger Mahony and executives from area businesses, the organization will, in March, fund five pilot shelters that address specific needs of homeless families, single women with children, single adults who are employable, and the chronically mentally ill.

Now, while the weather is cold, the Los Angeles City Council deserves credit for responding to the emergency. But even when the weather is sunny and warm, life on the streets is hard.

LOS ANGELES BUSINESS JOURNAL

February 23, 1987

EDITORIALS

One approach to the homeless . . .

"Look before you leap" is an apt adage. Its corollary is equally valid: "Know where you will land before you leap."

Los Angeles City Hall officials seem to have forgotten this when they launched a sweep of Skid Row last week to clean out homeless indigents.

In the beginning, officials hailed the sweep as a drive by police to root out drug dealing and other crime there. But when the sweep produced no arrests, officials changed the billing by admitting the mission really was to clean out camps of Skid Row homeless.

Accompanied by police, sanitation workers trucked off the pitiful possessions — broken chairs, discarded mattresses — of the homeless and were supposed to refer them to appropriate social agencies. Yet they already are overcrowded and out of vacant beds.

Officials certainly should have known this — especially after providing temporary shelter in City Hall during the recent cold snap. Thus, after the sweep the dispossessed homeless simply returned to their old Skid Row haunts — only now without the few carefully collected amenities which had made an awful existence just a tad more tolerable.

The sweep apparently was triggered by complaints from Central City East. While we empathize with that business group and its some 40 member companies in Skid Row, we note launching the sweep was both pointless and cruel without providing a new landing place for the homeless.

Moreover, we fail to see the point of using what everyone in City Hall admits are inadequate police resources on this fruitless activity when they are needed so badly for missions of far greater urgency.

. . . and one that works

Citing the urgent need for long-term solutions to the homeless crisis in Los Angeles, a consortium of leading companies and charitable foundations last week awarded grants of $100,000 each to five worthy shelters. The Greater Los Angeles Partnership for the Homeless made its first awards — with Mayor Tom Bradley in attendance — after being formally launched last summer. Major corporate sponsors of the shelter programs, according to Suzanne Campi, executive director, include Atlantic Richfield Co. and General Telephone, each giving $100,000; Southern California Gas Co., giving $50,000; and McDonnell Douglas/West, chipping in $25,000. Foundations donating money to Campi's organization include Weingart, Joseph Drown, Pfaffinger and Times Mirror.

At the receiving end of corporate Los Angeles' largess were the following: House of Ruth, a Boyle Heights agency that offers emergency housing for single women and women with children; Hill House & Union Station/The Depot, a Pasadena effort that provides emergency and short-term shelters for single men and families; People Assisting the Homeless, a West Los Angeles drop-in day center and 60-day "mainstream" program; Los Angeles Men's Place, a downtown Los Angeles mission that offers day services for mentally ill men; and Harbor Interfaith Shelter, a charitable program that cares for the homeless as they look for permanent housing. Campi says the Partnership's approach is unique in that it attempts to break the "cycle of homelessness. Our goal is to provide the homeless with the guidance and skills necessary to change and improve the quality of their lives."

The *Los Angeles Business* believes this is the most appropriate, effective and sensible way to solve this city's heart-wrenching problem. Only by providing meaningful counseling and referral services — which these five agencies apparently provide — can more of these disadvantaged people be returned to stable and productive lives.

We heartily applaud Campi's noble efforts and, speaking for the community as a whole, offer the sincerest thanks to the companies and foundations that made Campi's program possible.

Los Angeles Times METRO Editorial Pages
Friday, February 20, 1987 CC1/Part II

Group Awards $500,000 in Grants to Agencies Assisting Homeless

The Greater Los Angeles Partnership for the Homeless on Thursday announced grants totaling $500,000 to five shelters and service providers for the homeless in Los Angeles County.

The group, a coalition of businesses, foundations and community leaders that was formally organized seven months ago, raised the money, board Chairwoman Bettina W. Chandler said, "to help existing shelters to expand their services and break the cycle of homelessness."

The recipient agencies are the House of Ruth, an emergency and transitional housing service for single mothers with children in Boyle Heights; Hill House, Union Station and The Depot, a group that provides the homeless services in Pasadena; People Assisting the Homeless, which operates two facilities on the Westside; Harbor Interfaith Shelter in San Pedro, which assists homeless families with finding permanent housing, and Los Angeles Men's Place, which aids mentally ill men on Skid Row.

Corporate sponsors of the program include Arco, General Telephone, the Weingart Foundation, the Joseph Drown Foundation and the Times Mirror Foundation.

THE GREATER LOS ANGELES PARTNERSHIP FOR THE HOMELESS

3780 Wilshire Blvd., Ste. 1020, Los Angeles, California 90010 (213) 382-5050

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NEW GROUP FORMED TO HELP LOS ANGELES HOMELESS

In Los Angeles today, nearly 34,000 families and individuals live on the streets, earning our community the dubious distinction of having the largest homeless population in the United States. No longer concentrated in Skid Row, the homeless can be found in most residential areas as well, including Pasadena, Hollywood, Santa Monica, Long Beach and the San Fernando Valley. The homeless problem is worsening daily and has reached crisis proportions.

THE COMMUNITY'S RESPONSE: THE GREATER LOS ANGELES PARTNERSHIP FOR THE HOMELESS

In a concerted effort to address this problem, concerned business, religious and civic leaders recently established The Greater Los Angeles Partnership for the Homeless. A nonprofit corporation, The Partnership provides private sector leadership and financial support aimed at breaking the cycle of homelessness in our community. The Partnership's comprehensive regional plan defines priorities and targets resources. Its overriding purpose: to help individuals and families break out of the cycle of homelessness and re-establish productive lives in our society.

The Partnership's program goes beyond providing just food and shelter. Rather, it promotes and supports the effective delivery of the social services necessary to help the homeless re-enter mainstream society. These include counseling, job training and placement, assistance in securing government benefits and help in locating affordable housing. The Partnership will also address one of the major obstacles faced by individuals and families as they try to re-enter society — the inability to find affordable shelter. It will serve as a catalyst to initiate joint public-private ventures to create transitional and low-cost housing.

The Partnership's regional approach also enables it to serve as a coordinating vehicle to circulate information, strategies and resources among existing agencies scattered throughout the Los Angeles County region. It will provide technical assistance and management training to local shelters on such topics as long-range planning, board development, budget management and fund-raising in order to strengthen the efficiency, stability and future viability of these community agencies.

THE MODEL SHELTER PROGRAM: THE FIRST STEP

The Partnership's first funding project is the "Model Shelter Program." Through this $500,000 pilot demonstration project, The Partnership will identify five existing emergency shelters or programs for the homeless in Los Angeles County for development into model comprehensive care centers for the homeless. The Partnership will

award each facility $100,000 and work intensively with each to expand capacity, upgrade equipment, improve internal management systems and expand the range of professional services provided.

A primary goal of this pilot program will be to develop innovative and cost-effective means for delivering professional services to the homeless. At the end of this one-year pilot project, The Partnership will have developed models that other facilities interested in providing comprehensive social services and increasing their effectiveness can duplicate.

The Chronically Mentally Ill
This group, which comprises approximately 33% of the homeless population, has very special and different needs from the employable homeless. The mentally ill homeless require community-based programs which offer a supervised living arrangement in addition to ancillary social services and medical care. The Partnership's efforts for this constituency will be directed toward expanding and duplicating existing programs that provide these special living environments.

ANCILLARY PROGRAM EFFORTS

Public-Private Partnerships
The Partnership will leverage its resources and increase its effectiveness by developing joint funding and program efforts with government and private agencies. Efforts are already underway to develop such opportunities.

Community Volunteer Outreach
The Partnership will be in a unique position to recruit community volunteers for local homeless shelters because of its high visibility with this issue. The Partnership intends to work with shelters in identifying their volunteer needs and then help to train and place appropriate individuals. Volunteers may include skilled professionals such as psychologists, social workers, vocational counselors, attorneys, accountants and physicians as well as retired seniors and homemakers.

Affordable Housing
The Partnership will focus its housing efforts in the following areas: transitional housing, permanent low-cost housing for families, and permanent residential care facilities for the chronically mentally ill.

THE LEADERSHIP CAMPAIGN

The Partnership will be funded entirely by private donations. In order to successfully meet the challenge of the homeless crisis, The Partnership is seeking both leadership and financial commitments from local corporations, foundations and individuals. For this reason, The Partnership has launched a 3-year, $4 million fund-raising campaign.

While the homeless problem may seem overwhelming, The Partnership's strong private sector leadership and comprehensive approach can make a difference. Its innovative programs can serve as models nationwide as well as in Southern California.

Prepared Statement of Jim Schmidt, Executive Director, Fountain House

My name is Jim Schmidt. I am the Executive Director of Fountain House, a psychiatric rehabilitation program in New York City.

I very much appreciated being invited to speak before the Hearing on Jobs and Job Training for the Homeless conducted jointly by the House Education and Labor Committee and the House Committee on Aging. I hope the information I am about to provide will be of use to the Committees in their deliberations.

One sub-population in the homeless category are those men and women who, in addition to being homeless, are considered to be seriously mentally ill. This is a grouping we work with at Fountain House and we have had some success in providing these men and women not only with housing, but with the opportunity they need to become productively involved in the activities of our clubhouse. Once involved, they discover, through a program called Transitional Employment developed in cooperation with business and industry, that they can hold a job, at first on a transitional, temporary basis, and then, on a full-time, independent basis.

Working with the mentally ill and the mentally ill homeless often takes time, but the results in our view have been well worth it.

The clubhouse model of psychiatric rehabilitation developed at Fountain House provides, first and foremost, a place where the mentally ill are welcomed and celebrated, and very much needed. Each day, some 350 individuals (called "members") come in and work alongside staff in running the clubhouse, doing many, many different things, ranging from shopping for, preparing and serving a lunch for over 250 members, answering our switchboard, doing a wide variety of clerical tasks, running our snack bar seven days a week, assisting in the research activities conducted at Fountain House, and maintaining contact on a reach out basis with those members who have become rehospitalized or are isolated in the community; and of course, everybody chips in to help keep the house clean.

Fountain House currently provides housing opportunities for 180 of its

members in scattered apartments around the city and in three group residences. We expect in the next year or two to be able to accommodate an additional 104 people in housing programs which are being developed with the assistance of the U.S. Department of Housing & Urban Development and the New York State Office of Mental Health, and the New York City and New York State departments concerned with housing for the homeless.

For the mentally ill, housing in and of itself is not enough. They need to be provided with membership in some part of society, in this instance, the clubhouse at Fountain House. As members of Fountain House, they discover the contribution they can make to their own lives and the lives of others. Participation at Fountain House enables members to effectively access and utilize necessary clinical and medical services. Fountain House is a place where people have friends and discover their self worth and gain confidence in their ability to move on to higher levels of adjustment.

Environments like Fountain House also provide the opportunity to go to work on real, paid jobs in industry in a program called transitional employment, or TE.

Each day, 130 of our members go to work in some 35 New York City business firms on a part-time basis with each "placement" lasting approximately six months. Members usually have two, three or four of these part-time jobs before they are ready to secure jobs of their own. An important aspect of transitional employment is the "right to fail". A member can try a job and not succeed, but come back and try another transitional job in a few weeks or months later. If a member fails, the job is filled by a staff worker until another member is available to take over the job. In transitional employment, we guarantee our members the opportunity to go to work, and guarantee the employer that the job will be done.

Members of Fountain House currently earn as a group a total of $600,000 a year on transitional employment placements which reduces their dependence on public assistance or Social Security benefits. But more importantly, transitional employment enables our members to discover that they can work again earn a real job reference, and develop those behaviors which are so essential to job success.

Some 133 programs modelled after Fountain House which include Transitional Employment have been replicated across the country, and today, nationwide, a total of 825 employers are providing job opportunities to close to 2,000 participants in these programs, with total annual earnings of $8,225,000.

Following my remarks, you will hear from some of our members who were homeless prior to joining Fountain House. The first is Ben Faxas, speaking before our annual meeting for transitional employers which was held this year on February 24th.

We have also excerpted segments from a program entitled "Sane Asylums", presented by WNET in New York on February 11th, which focussed entirely on the homeless mentally ill in New York City. The segment starts out with Ben talking. This video tape was put together by members who work together in our Audio-Visual Department.

We would be pleased to have any of you or your staff visit Fountain House should you be in the New York area, and we will be glad to provide any further information you might require.